

<i>SERFF Tracking Number:</i>	<i>MHPL-126444604</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Mercy Health Plans</i>	<i>State Tracking Number:</i>	<i>44558</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H16I Individual Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16I.005A Individual - Preferred Provider (PPO)</i>
<i>Product Name:</i>	<i>Arkansas Individual 2010 - New Block</i>		
<i>Project Name/Number:</i>	<i>Arkansas Individual 2010 - new block of business/</i>		

## Filing at a Glance

Company: Mercy Health Plans

Product Name: Arkansas Individual 2010 - New SERFF Tr Num: MHPL-126444604 State: Arkansas Block

TOI: H16I Individual Health - Major Medical SERFF Status: Closed-Approved- Closed State Tr Num: 44558

Sub-TOI: H16I.005A Individual - Preferred Provider (PPO) Co Tr Num: State Status: Approved-Closed

Filing Type: Form/Rate

Author: Wanda Thurman

Date Submitted: 01/13/2010

Reviewer(s): Rosalind Minor

Disposition Date: 02/01/2010

Disposition Status: Approved-Closed

Implementation Date Requested: 03/01/2010

Implementation Date:

State Filing Description:

## General Information

Project Name: Arkansas Individual 2010 - new block of business

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 02/01/2010

Deemer Date:

Submitted By: Wanda Thurman

Filing Description:

January 6, 2010

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 02/01/2010

Created By: Wanda Thurman

Corresponding Filing Tracking Number: MHPL-126444604

Ms. Rosalind Minor

Senior Certified Rate and Form Analyst

Arkansas Insurance Department

SERFF Tracking Number: MHPL-126444604 State: Arkansas  
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(PPO)  
Product Name: Arkansas Individual 2010 - New Block  
Project Name/Number: Arkansas Individual 2010 - new block of business/

Life and Health Division  
1200 West Third Street  
Little Rock, AR 72201-1904

RE: AR INDIV COC/LT-2010, et al.  
NAIC: 11529

Dear Ms. Minor:

I am submitting the above mentioned documents for your review and approval along with the required Policy Form Compliance Certification and a filing fee of \$50. A check in the amount of \$50 will be Federal Expressed to you. This is a new block of business for the individual comprehensive major medical PPO product, MercyOne. The tentative effective date requested for this filing is March 1.

All documents are new and significantly different from our current individual block of business in these ways:

1. Cost share for the plan designs has changed
2. Out-of-Pocket Maximum will include deductible and coinsurance
3. Maternity will not be offered

Mercy Health Plans has compared our MercyOne benefits to our competitors and have found our benefit structure creates additional cost and selection issues. Our goal is to reposition MercyOne as a viable plan in the State of Arkansas.

Please contact me at (314) 214-8132 or by email at wthurman@mercy.net if you have any questions.

Sincerely,

Wanda Thurman  
Compliance Analyst

## Company and Contact

### Filing Contact Information

Wanda Thurman, Compliance Analyst Wanda.Thurman@mercy.net

SERFF Tracking Number: MHPL-126444604 State: Arkansas  
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Product Name: Arkansas Individual 2010 - New Block  
 Project Name/Number: Arkansas Individual 2010 - new block of business/

14528 South Outer Forty Rd. 314-214-8132 [Phone]  
 Suite 300 314-214-8103 [FAX]  
 Chesterfield, MO 63017

### Filing Company Information

Mercy Health Plans	CoCode: 11529	State of Domicile: Missouri
14528 South Outer Forty Rd.	Group Code:	Company Type: LAH/PPO
Suite 300	Group Name:	State ID Number:
Chesterfield, MO 63017	FEIN Number: 48-1262342	
(314) 214-8100 ext. [Phone]		

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### Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
0000210071	\$50.00	12/21/2009
	\$0.00	

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(PPO)  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/01/2010	02/01/2010

SERFF Tracking Number:	MHPL-126444604	State:	Arkansas
Filing Company:	Mercy Health Plans	State Tracking Number:	44558
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## Disposition

Disposition Date: 02/01/2010

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Mercy Health Plans	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: MHPL-126444604 State: Arkansas

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TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)

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Schedule	Schedule Item	Schedule Item Status	Public Access
<b>Supporting Document (revised)</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Flesch Certification	Replaced	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	No
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	Age and Gender Factor - revised	Approved-Closed	No
<b>Form</b>	Certificate of Coverage	Approved-Closed	Yes
<b>Form</b>	Schedule of Coverage and Benefits	Approved-Closed	Yes
<b>Form (revised)</b>	MercyOne Application Checklist	Approved-Closed	Yes
<b>Form</b>	MercyOne Application Checklist	Replaced	Yes
<b>Form</b>	Birth Control Services Addendum	Approved-Closed	Yes
<b>Form</b>	Family Services Rider	Approved-Closed	Yes
<b>Form</b>	Craniomandibular and Temporomandibular Joint Disorder (TMJ) Rider	Approved-Closed	Yes
<b>Form</b>	Outpatient Prescription Drug Addendum	Approved-Closed	Yes
<b>Rate</b>	MHP Arkansas - New Plans 2010 - Exhibit 1	Approved-Closed	No
<b>Rate (revised)</b>	Age and Area Factors - Exhibit 2	Approved-Closed	No
<b>Rate</b>	Age and Area Factors - Exhibit 2	Replaced	No
<b>Rate</b>	Arkansas Individual Rates - Exhibit 3	Approved-Closed	No
<b>Rate</b>	Arkansas Individual Rates - Attachment 4	Approved-Closed	No

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TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)

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## Form Schedule

### Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/01/2010	AR INDIV COC/LT- 2010	Policy/Cont ract/Fratern Coverage al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider		Initial			AR INDIV COC_2010.p df
Approved-Closed 02/01/2010	AR INDIV SCH/LT_20 10	Schedule Pages Benefits	Schedule of Coverage and Benefits	Initial			AR INDIV Schedule_ 2010.pdf
Approved-Closed 02/01/2010	AR INDIV APP/LT v.2 (2010)	Application/ Enrollment Form	MercyOne Application Checklist	Initial			AR Individual Application_ 2010_REVIS ED 1.27.10.pdf
Approved-Closed 02/01/2010	AR INDIV- BIRTH CONTROL RIDER (01- 10)	Policy/Cont ract/Fratern Services Addendum al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider		Initial			AR INDIV- BIRTH CONTROL RIDER_2010. pdf
Approved-Closed 02/01/2010	AR INDIV- FAM RIDER (01- 10)	Policy/Cont ract/Fratern Rider al Certificate:	Family Services	Initial			AR INDIV- FAM RIDER _2010.pdf

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<i>Project Name/Number:</i>	<i>Arkansas Individual 2010 - new block of business/ Amendmen t, Insert Page, Endorseme nt or Rider</i>		
Approved- Closed 02/01/2010	AR INDIV- TMJ RIDER (01- 10) Policy/Cont Craniomandibular ract/Fratern and Temporomandibular Certificate: Joint Disorder (TMJ) Amendmen Rider t, Insert Page, Endorseme nt or Rider	Initial	AR INDIV- TMJ RIDER_2010. pdf
Approved- Closed 02/01/2010	AR INDIV- DRUG RIDER (01- 10) Policy/Cont Outpatient ract/Fratern Prescription Drug Addendum Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	AR INDIV DRUG RIDER_2010. pdf

**[YEAR]**

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# **Individual Comprehensive Health Insurance Policy**

**Issued by: Mercy Health Plans**

[www.mercyhealthplans.com](http://www.mercyhealthplans.com)

**This Policy is guaranteed renewable**

## **Policy for Non-Occupational Injury and Non-Occupational Illness**

**NOTICE:**

This Policy is underwritten by Mercy Health Plans. The Benefits and main points of coverage under the Plan are set forth in this Policy and Schedule of Coverage and Benefits and any attached Riders. The Benefits are effective only while You are covered by the Individual PPO Policy.

This Policy describes the Benefits for health care services provided by Mercy Health Plans and the extent to which Benefit Payment may be limited. The Policy may be terminated by Mercy Health Plans or by You as described in this Policy.

**You may return this Policy within ten (10) days of its receipt for full refund of any Premiums paid if, after examining it, You are not satisfied for any reason. Written notification is required to return this Policy. If services are utilized during this (10) day period, this policy is assumed to be accepted. Any coverage returned for a refund of Premium will be null and void from its inception.**

**Mercy Health Plans  
First Security Center  
521 President Clinton Avenue, Suite 700  
Little Rock, Arkansas 72201  
866-647-5568**

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## Individual Comprehensive Health Insurance Policy

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This Policy is a legal document between **Mercy Health Plans** (“**The Plan**”, “**We**”, “**Us**”, “**Our**”) and **the Enrolling Individual** (“**You**”, “**Your**”) to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrollee’s application and payment of the required Policy Premium.

The Policy includes:

- Any Amendments and Riders
- The Schedule of Coverage and Benefits and any Inserts to the Individual Comprehensive Health Insurance Policy

### Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of the Policy. When that happens We will send You the revised Policy, Rider or Amendment pages.

No one has the authority to make any changes to this Policy unless those changes are in writing and signed by an officer of Mercy Health Plans. No change shall be valid until approved and made part of this Policy. Only the Plan has the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law, without Your approval.

### Information You Should Have

This Policy describes Benefits in effect as of Effective Date of Policy Issuance.

On its Effective Date, this Policy replaces and overrules any Policy that We may have previously issued to You. This Policy will in turn be overruled by any Policy We issue to You in the future.

Coverage under the Policy will begin at 12:01 a.m. on the Effective Date and end at 12:00 midnight on the Termination Date. The Policy will remain in effect as long as the Policy Premiums are paid when they are due, subject to termination of the Policy.

**This Policy will renew automatically every 12 months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period. We must receive Your termination notice prior to Your requested date of termination. If a request for termination notice is received, the Policy will term at the end of the month in which the notice was received.**

We are delivering the Policy in the State of Arkansas. The laws of the State of Arkansas govern this Policy.

The validity of the Policy will not be contested after the Policy has been in force for three (3) years from the date of issue. No statement relating to insurability made by any person covered under the Policy will be used to contest the validity of the Policy after it has been in force for a period of two (2) years. In addition, the statement must be contained in a written instrument signed by the person making the statement. The assertion, at any time, of defenses based upon the person’s ineligibility for coverage under the Policy or upon other provisions in the Policy will not be precluded.

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## Section 1: Introduction to Your Policy

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**We encourage You to read Your Policy and any attached Riders and/or Amendments carefully.**

### Information about Defined Terms

Because this Policy is part of a legal document, We want to give You information about the document that will help You understand it. Certain capitalized words have special meanings. We have defined these words in Section 14 (Definitions of Terms). You can refer to Section 14 as You read this document to have a clearer understanding of Your Policy of Coverage.

When We use the words “**The Plan**”, “**We**”, “**Us**”, and “**Our**” in this document, We are referring to **Mercy Health Plans**. When We use the words “**You**” and “**Your**” We are referring to people who are **Covered Persons** as the term is defined in Section 14 (Definitions of Terms).

This Policy and the other Policy documents describe Your Benefits as well as Your rights and responsibilities under the Policy.

We especially encourage You to review the Benefit limitations of this Policy by reading Section 12 (Covered Benefits) and Section 13 (Exclusions.) You should also carefully read Section 11 (General Provisions) to better understand how this Policy and Your Benefits work. You should call Us if You have questions about the coverage available to You.

Many of the sections of the Policy are related to other sections of the document. You may not have all of the information You need by reading just one Section. We also encourage You to keep Your Policy and any attachments in a safe place for Your future reference.

Please be aware that Your Physician does not have a copy of Your **Policy**, and is not responsible for knowing or communicating Your Benefits.

### Required Premiums, Premium Changes and Grace Period

The Plan requires automatic withdrawal of Premiums each month for this Policy. You must pay the required Premium within a 31-day grace period from the Premium due date to keep this Policy in force. All Premiums must be paid via any one of the following methods:

- ACH Direct Debit Program
- Credit Card payment
- A check for the entire annual Premium

Your Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this Policy at any time during each 12-month period. We must receive Your termination notice prior to the end of the month You wish to terminate Your Policy.

Upon the payment of a claim under this Policy, any Premium then due and unpaid or covered by any note or written order may be deducted from the claim payment. We may change the amount of Your Premiums on any monthly due date upon giving You thirty (30) days prior written notice.

We may change the terms and conditions of this Policy to conform to the laws of the State of Arkansas, to conform to Federal law or to conform to underwriting policies established by Mercy Health Plans after submission to and approval by the Arkansas Insurance Department. For changes in terms and conditions, We must give written notice thirty (30) days before the change. This notice may be in the form of a new Policy or a Rider or Amendment to this Policy.

### Don't Hesitate to Contact Us

Throughout the document, You will find statements that encourage You to contact Us for further information. Whenever You have a question or concern regarding Your Benefits, please call Us using the telephone number for Our Customer Contact Center listed on Your ID card.

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## Section 2: Eligibility

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### How to Enroll

If Eligible, the Enrolling Individual must complete an enrollment application and submit the properly completed form to Us, along with any required Premium. We will not provide Benefits for health services that You receive before Your Effective Date of coverage.

### If You Are Hospitalized When Your Coverage Begins

If You are a patient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the Effective Date of this Policy, We will pay Benefits for Covered Health Services related to that Inpatient Stay as long as You receive Covered Health Services in accordance with the terms of the Policy.

If You are hospitalized when Your coverage begins, You should notify Us within forty-eight (48) hours of Your Effective Date, or as soon as is reasonably possible. Network Benefits are available only if You receive Covered Health Services from Network Providers.

### If You Are Eligible for Medicare

**If You are eligible for Medicare, You are not eligible to begin or continue coverage under this Policy.**

### Who is Eligible for Coverage?

#### Subscriber

When You enroll in the Plan, We refer to You as a Subscriber. For a definition of Eligible Person and Subscriber, see Section 14 (Definitions of Terms).

To be eligible for this coverage, Your primary domicile and residence must be within Arkansas.

If both Spouses are Eligible to enroll, each may enroll as a Subscriber, or one Spouse may enroll as a Dependent of the other, but not both.

Children who are ages 6 months – 18 years may qualify as eligible persons under a Child Only Policy.

Except as We have described in Section 3 (When Coverage Begins), You may not enroll without acceptance by the Plan.

#### Dependents

Dependent generally refers to the Subscriber's Spouse and children. When a Dependent actually enrolls, We refer to that person as an Enrolled Dependent. Dependents may include Full-Time Students ages 19 - 23. Unmarried children under age 19 years, or who are full time students (FTS) through the date on which they turn 23 years of age may be added to the Plan. For a complete definition of Dependent and Enrolled Dependent, or Full-Time Student, see Section 14 (Definitions of Terms).

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

Enrollment of a Dependent child will not be denied for any of the following reasons:

- The child was born out of wedlock
- The child is not claimed as a Dependent on Your Federal income tax return
- The child does not reside with You

The Subscriber must reimburse Us for any Benefits that We pay for a child at a time when the child did not satisfy these conditions.

Except as We have described in (Section 3: When Coverage Begins), Dependents may not enroll without acceptance by the Plan.

## Who is not Eligible to Enroll?

Persons not eligible for coverage include -

- a) Those whose coverage was previously terminated for the following causes:
  - Fraud or misrepresentation in the Application
  - Abuse of services or facilities
  - Improper use of ID Card
  - Misconduct detrimental to Plan operations and the delivery of services
  - Failure to pay Premiums more than twice in the past [6] [12] months, or to pay Premiums in a timely manner in accordance with the terms of the Policy.

Refer to Section 4 (When Coverage Ends) for a detailed description of these causes that lead to termination.

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## Section 3: When Coverage Begins

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### Initial Enrollment Period

The Initial Enrollment Period is the first time You enroll yourself and/Your eligible dependents, subject to acceptance by the Plan. Coverage begins on the Effective Date as determined by the Plan in coordination with when required Premium is received.

### Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth
- Legal adoption
- Placement for adoption
- Marriage
- Legal permanent general guardianship
- Court or administrative order

The Subscriber may apply for coverage for the following Dependents as described below; however, application for Dependent (s) will be subject to any applicable underwriting requirements if it is received after -

- Ninety (90) days of birth;
- Sixty (60) days of the filing of a petition for adoption or placement of a child for adoption.

Newborn children of the Subscriber and/or Subscriber's Spouse, who are Members, will be covered for the lesser of: (a) 5 days from birth, or (b) mother's discharge, if family/Dependent coverage is available through the Subscriber's Policy on the date of birth, and the Subscriber elects Dependent coverage (if not previously elected) within ninety (90) days after the date of birth. Coverage will include necessary care and treatment of medically diagnosed Congenital defects and birth abnormalities, including premature birth.

A newly adopted child, including a newborn, will be covered under the Plan effective from the date of birth, if We receive an application submitted on his/her behalf within sixty (60) days of the date You filed a petition for adoption of the child for which You have physical custody and who is under Your charge, care and control. Coverage will begin on the date of the filing of the petition for adoption, or from the moment of birth, if the petition is filed for adoption of a newborn within sixty (60) days after the birth of the child. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. 'Placement' means in the physical custody of the adoptive parent. For coverage, You must notify the Plan, submit an application for Your new Dependent, and pay the required Premium.

Newly acquired Dependent by marriage, or by legal permanent guardianship, or placement in your physical custody by a court or administrative order will be subject to underwriting requirements and will be covered as of the Effective Date identified upon approval of their application for coverage.

## Coverage for a Disabled Child

Coverage for an unmarried Enrolled Dependent child who is disabled because of a mental or a physical disability will not end just because the child has reached a certain age. We will extend the coverage for the disabled child beyond the limiting age if both of the following are true:

- The disabled child is not able to be self-supporting because of a mental or physical disability; **and**
- The disabled child depends primarily on the Subscriber for support and maintenance due to the mental or physical disability.

Coverage will continue as long as the Enrolled Dependent is disabled and continues to satisfy both of these qualifying conditions, unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask You to furnish Us with proof of the disabled child's incapacity and dependency after the date coverage would otherwise have ended because the child reached a certain age. We may continue to ask You for proof that the disabled child still meets these two conditions, but will not ask more than once per year. The proof We ask for might include medical examinations at Our expense.

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## Section 4: When Coverage Ends

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### General Information about When Coverage Ends:

- We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.
- Your entitlement to Benefits automatically ends on the date that coverage ends, even if You are hospitalized or are otherwise receiving medical treatment on that date.
- When Your coverage ends, We will still pay claims for Covered Health Services that You received before Your coverage ended. However, once Your coverage ends, We do not provide Benefits for health services that You receive for medical conditions that occurred after Your coverage ended.

### Events Ending Your Coverage

Your coverage ends on the earliest of the dates specified in the following outline:

Event	Description
<b>The Entire Individual Policy Ends</b>	<p>Your coverage ends on the date the Individual Policy ends. The Plan is responsible for notifying You that Your coverage has ended:</p> <p>If We terminate the Policy because We will no longer issue this particular type of Individual health benefit plan within the applicable market, We will provide at least ninety (90) days prior written notice to the Enrolling Individual and all Covered Persons.</p>
<b>You Are No Longer Eligible for Coverage</b>	<p>Your coverage ends on the date We determine that You are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to Section 2 (Eligibility) and Section 14 (Definitions of Terms) for more information.</p> <p><b>When You turn age 65 or become eligible for Medicare, You are no longer eligible for coverage.</b></p> <p>If Your coverage ends due to Your death and We receive notification within one (1) year of Your death, Premiums paid for coverage beyond the date of Your death will be refunded to You or Your estate within thirty (30) days after We receive written proof of Your death.</p>
<b>We Receive Notice to End Coverage</b>	<p>Your coverage ends at the end of the month that We receive Your request in writing. We must receive Your termination notice prior to Your requested date of termination. Your Policy will renew automatically every twelve (12) months from the date that Your coverage begins. You must notify Us in writing if You want to terminate this policy at any time during each 12-month period.</p>
<b>Full-Time Student Status Ends</b>	<p>Coverage of an Enrolled Dependent child who loses Full-Time Student status due to a Medically Necessary leave of absence will not terminate until the earlier of:</p> <ul style="list-style-type: none"><li>▪ One (1) year from the first day of the Medically Necessary leave of absence, or</li><li>▪ The date on which such coverage would otherwise terminate under the terms of this Policy.</li></ul> <p>We will ask You for proof of any medical leave of absence, which must be certified by the Dependent's attending physician.</p>
<b>Fraud, Misrepresentation</b>	<p>Your coverage ends on the date We identify in a notice that Your coverage is terminated because of fraud or misrepresentation. We will provide written notice to the Subscriber that</p>

Event	Description
<b>or False Information</b>	<p>coverage has ended.</p> <p>During the first three (3) years that the Policy is in effect, if You provided Us with false information or misrepresentation of material facts regarding Your application or coverage, We have the right to demand that You pay back all Benefits We paid to You, or paid in Your name, during the time You were incorrectly covered under the Policy. After the first three (3) years, We can only demand that You pay back these Benefits if the written application contained a fraudulent misstatement.</p>
<b>Abuse of Services or Facilities</b>	<p>In the event of abuse by a Covered Person in the use of services or facilities, that person's coverage may be restricted or canceled by the Plan upon at least thirty-one (31) days prior written notice to the Member.</p>
<b>Improper Use of ID Card</b>	<p>Your coverage ends when You permit an unauthorized person to use Your ID card, or You use another person's card.</p> <p>When Your coverage is terminated because of improper use of Your ID card, We will provide written notice to the Subscriber that coverage has ended on the date We identify in the notice.</p>
<b>Misconduct</b>	<p>In the event Your misconduct is detrimental to the safety of Plan operations and the delivery of services, Your coverage may be canceled immediately.</p>
<b>Death of Subscriber</b>	<p>Coverage ends for the Subscriber as of the date of the Subscriber's death.</p>
<b>Non-Payment of Premiums</b>	<p>This Policy will automatically end on the last day of the period for which Premiums have been paid, if Premiums are not paid within the grace period when due. The grace period is thirty-one (31) days from the Premium due date.</p>
<b>Reinstatement of Coverage</b>	<p>If Premium is not paid by the end of the grace period (thirty-one (31) days from the Premium due date), coverage will end as of the date to which Your last Premium was paid. However, this Policy may be reinstated. After You receive a termination notice from Us, You will have five (5) working days to notify Us in writing of Your desire to reinstate Your Policy.</p>
	<p><b>Reapplication for Coverage</b></p> <p>If You fail to request reinstatement within five (5) working days of receipt of a termination notice from Us and want to renew Your coverage, You will have to reapply for a new individual Policy. However, You may not reapply for coverage for a period of twelve (12) months from the date Your coverage ended due to nonpayment of Premiums.</p>
<b>Moving Out of State</b>	<p>You are required to notify Us if You move Your residence outside of the state of Arkansas. Your coverage will be terminated 30 days after the date You provide Us in the notice. If You move Your residence outside of the state of Arkansas without prior notice to Us, We will terminate Your coverage as of the date We determine that You were no longer a resident of Arkansas.</p>

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## Section 5: How You Get Care

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### Identification cards

We will send You an identification (ID) card when You enroll. You should carry Your ID card with You at all times. You must show it whenever You receive services from a Network Provider, or fill a prescription at a Network pharmacy. If You do not show Your ID card, Network Providers have no way of knowing that You are enrolled under Our PPO Policy. As a result, they may bill You for the entire cost of the services You receive.

If You do not receive Your ID card within thirty (30) days after the Effective Date of Your enrollment, or if You need replacement cards, call Us at 866-450-3249 or 417-836-0475. You may also request replacement cards through Our Web site: [www.mercyhealthplans.com](http://www.mercyhealthplans.com). You must show Your ID card every time You request Health Care Services from a Network Provider.

### Where You get covered care:

You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits You must see a Network Physician or other Network Provider.

Benefits are available only if all of the following are true:

- Covered Health Services are received while the Individual Policy is in effect;
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in Section 4 (When Coverage Ends) occurs;
- The person who received Covered Health Services is a Covered Person and meets all eligibility requirements specified in this Policy.

You will only pay Copayments, Deductibles, and/or Coinsurances when receiving care from a Network Provider for a Covered Health Service. If You use Non-Network Providers, it will cost You more.

#### • Network Providers

Network Providers are physicians and other health care professionals that We contract with to provide Covered Services to Our Members. Network Providers are independent practitioners. They are not Our employees. It is Your responsibility to select Your provider. We credential Network Providers according to national standards. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

A directory of Network Providers is available on Our website at [www.mercyhealthplans.com](http://www.mercyhealthplans.com). We update the *Provider Directory* periodically, however, before obtaining services You should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling Our Customer Contact Center at the telephone number listed on Your Identification Card.

It is possible that You might not be able to obtain services from a particular Network Provider. The Network of providers is subject to change. You might find that a particular Network Provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to You, You must choose another Network Provider to get Network Benefits.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract with Us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network Providers choose to be a Network Provider for only some of Our products. Refer to Your provider directory or contact Us for assistance.

#### • Extended Provider Network

Mercy Health Plans has an extended provider network **outside** of Our Service Area through Multiplan, Inc. This extended Provider Network is available to You as Network Benefits only when you are **outside** of Our Service Area. To find a Provider, call Our Customer Contact Center or visit [www.mercyhealthplans.com](http://www.mercyhealthplans.com).

This extended provider network is not available when you receive services **within** Mercy Health Plans' Service Area. (Note: The Mercy Health Plans' service area includes all counties in the state of Arkansas.)

- **Network Benefits** Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services that are described as Network Benefits in Section 12 (Covered Benefits) and are any of the following:
  - Provided by a Network Physician or other Network Provider
  - Emergency Room Services

Please note that Mental Health/Substance Abuse Services must be authorized by the Mental Health/Substance Abuse Designee. Please see Section 12 (Covered Benefits) under the headings for Mental Health and Substance Abuse Services.
- **Designated Facilities and Other Providers** If You have a medical condition that We believe needs special services, We may direct You to a Designated Facility or other Network Provider chosen by Us. Network Benefits will only be paid if Your Covered Health Services for that condition are provided by, or arranged by the Network Designated Facility or other Network Provider chosen by Us. Non-Network Benefits will apply to any Non-Network facility or provider.
- **Non-Network Benefits** Non-Network Benefits are generally paid at a lower level than Network Benefits. Non-Network Benefits are payable for Covered Health Services that are provided by Non-Network Physicians or Non-Network Providers.

## What You must do to get covered care

You or Your Physician must notify Us and obtain **Prior Authorization** before getting certain Covered Health Services from either Network or Non-Network Providers. A current list of those services and supplies requiring Prior Authorization is available by calling Our Customer Contact Center at the number listed on Your ID Card, or by visiting [www.mercyhealthplans.com](http://www.mercyhealthplans.com). Verify with your Physician, or Our Contact Center, the authorized date range, and the number and type of services.

We urge You to confirm with Us that the services You plan to receive are Covered Health Services. Prior Authorization does not mean Benefits are payable in all cases. That is because in some instances, certain procedures may not meet the definition of a Covered Health Service and, therefore, are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling *before* You receive treatment, You can check to see if the service is subject to limitations or exclusions including, but not limited to:

- The Cosmetic Procedures exclusion. Examples of procedures that may or may not be considered cosmetic include breast reconstruction; vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty.
- The Experimental, Investigational or Unproven Services exclusion.
- Any other contract limitation or exclusion.

Please note the following:

- You will be responsible for all costs associated with a non-covered service.
- Failure to obtain prior authorization of certain Covered Services may result in a reduction of Eligible Expenses. You will be held responsible when using a Non-Network Provider in a non-emergent or non-urgent situation, if the Non-Network Provider fails to obtain Prior Authorization when required.
- If a Network Provider fails to obtain Prior Authorization when required, You will be held harmless; however, if You seek services outside Our Network, You will be responsible to make sure that any necessary Prior Authorizations are obtained.

**Note:** Mental Health and Substance Abuse services must be Prior Authorized by the Mental Health/Substance Abuse Designee. Please see Section 12 (Covered Benefits) under the headings for Mental Health and Substance Abuse services.

- **Care Management**

When You notify Us as described above, We will work together to implement the care management process and to provide You with information about additional services that are available to You, such as disease management programs, health education, pre-admission counseling and patient advocacy.

## **Emergency Room Services**

We provide Benefits for Emergency Room Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

Network Benefits are paid for Emergency Room Services, even if a Non-Network Provider provides the services. Emergency Services and any follow-up care rendered by a Non-Network Provider must be:

- 1) Of such immediate nature that Your health would be jeopardized if taken to a Network Hospital where the services of a Participating Physician would be available, or
  - 2) Provided under circumstances under which You are unable, due to Your condition, to request treatment at a location where the services of a Participating Physician would be available.
- If You are admitted as an inpatient to a Network or Non-Network Hospital after You receive Emergency Room Services, We must be notified within two (2) working days or on the same day of admission, or as soon as reasonably possible, to receive authorization for continued services. Continuation of care as for any Inpatient Stay requires Prior Authorization and approval by the Plan.
  - If You are admitted as an inpatient to a **Non-Network Hospital** after You receive Emergency Room Services, We may elect to transfer You to a Network Hospital as soon as it is medically appropriate to do so. If You choose to stay in the Non-Network Hospital after the date We decide a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.
  - If You are admitted as an inpatient to a **Network** or **Non-Network Hospital** within twenty-four (24) hours of receiving treatment for the same condition as an Emergency Room Service, You will not have to pay the Copayment/Coinsurance for Emergency Room Services. The Copayment/Coinsurance for an Inpatient Stay in a Network Hospital will apply instead.

## **Urgent Care Services**

Covered Health Services that are required to prevent serious deterioration of Your health within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms. Urgent care is not the same as Emergency Care.

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## Section 6: Your Cost for Covered Services

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This is what You will pay for covered care:

### Copayments

A Copayment is a fixed amount of money You pay to the provider, facility, pharmacy, etc., when You receive *certain* services. **Copayments do not count towards Your Out-of-Pocket Maximum or Your Deductible.** Copayment amounts are listed on the Schedule of Coverage and Benefits next to the description for each Covered Health Service.

### Coinsurance

Coinsurance is the percentage of Our Eligible Expenses that You must pay for Your care. Coinsurance does not begin until after You meet Your Deductible. **Coinsurances count toward Your Out-of-Pocket Maximum. Coinsurance amounts are listed on the Schedule of Coverage and Benefits next to the description for each Covered Health Service.**

### Deductible

A Deductible is a fixed expense You must incur within a Calendar Year for certain Covered Services and supplies before We start paying Benefits for them. For a complete definition of [annual Deductible, see Section 14 (Definitions of Terms).

NOTE: Charges that apply to one Deductible (e.g., Network Deductible) do not apply to the other (e.g., Non-Network Deductible).

**Deductibles do apply to Your Out-of-Pocket Maximum.**

**For Your Annual Deductible See Your Schedule of Coverage and Benefits.**

### Eligible Expenses

Eligible Expenses are the amount We determine that We will pay for Benefits minus any Copayment, Coinsurance or Deductible. We will pay a contracted rate for Network Providers. For Non-Network Providers, however, We will pay the Usual and Customary Rate (UCR) as determined by Us. For a complete definition of Eligible Expenses and UCR that describes how We determine payment, see Section 14 (Definitions of Terms).

**Charges in Excess of UCR:** Charges by a provider in excess of UCR will not be covered under this Policy and will not be counted toward Your Out-Of-Pocket Maximum limit or Deductible.

For Network Benefits, You are not responsible for any difference between the Eligible Expenses and the amount the provider bills, but You are responsible for all Copayments, Coinsurances or Deductibles.

For Non-Network Benefits, You are responsible to pay directly to the Non-Network Provider any difference between the amount the provider bills You and the UCR amount We will pay for Eligible Expenses. Please see Section 13 (Exclusions).

### Out-of-Pocket Maximum

The maximum You pay out of Your pocket in a [Calendar] [Rolling] [Plan] Year for Coinsurances and Deductibles. For a complete definition of Out-of-Pocket Maximum, see Section 14 (Definitions of Terms).

The Out-of-Pocket Maximum does **not** include any of the following:

- Any charges for non-Covered Health Services;
- Copayments] for Covered Health Services available by an optional Rider;
- The amount of any reduced Benefits if You do not obtain Prior Authorization as described in Section 12 (Covered Benefits) ;
- Charges that exceed Eligible Expenses;
- Any Copayments for Covered Health Services in Section 12 (Covered Benefits);

**For Your Out-of-Pocket Maximum see Your Schedule of Coverage and Benefits.**

### Maximum Policy Benefit

The maximum amount that We will pay for Benefits during the entire period of time You are enrolled under this Policy. For a complete definition of Maximum Policy Benefit, see Section 14 (Definitions of Terms)

**For Your Maximum Policy Benefit see Your Schedule of Coverage and Benefits.**

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## Section 7: How to File a Claim

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- **Network Provider**

We pay Network Providers directly for Your Covered Health Services, so Network Providers file claims on Your behalf to Us. If a Network Provider bills You for any Covered Health Service, contact Us. However, You are responsible for meeting any Annual Deductible and for paying Copayments or Coinsurance to a Network Provider at the time of service, or when You receive a bill from the provider.

- **Non-Network Provider**

When You receive Covered Health Services from a Non-Network Provider, You may be responsible for paying for all expenses up front and then requesting reimbursement from Us.

### How to File a Claim

**While You do not need to fill out a specific claim form, You must file the claim in a format that contains all of the information We require, as described below.**

If a Subscriber provides written authorization to a Non-Network Provider for payment of medical Benefits for any Eligible Expenses, reimbursement may be paid directly to that Provider. If the subscriber did not sign authorization for payment of medical Benefits, the Subscriber may be responsible for paying for all expenses up front and then requesting reimbursement from Us. We will not reimburse third parties who have purchased or been assigned Benefits by Physicians or other providers.

### Required Information for Claims

When You request payment of Benefits from Us, You must provide Us with all of the following information:

1. The Subscriber's name and address;
2. The patient's name and date of birth;
3. The Member number stated on Your ID card;
4. The name, address, phone number and Tax ID of the provider of the service(s);
5. A diagnosis from the Physician;
6. An itemized bill from the provider of service that includes the Current Procedural Terminology (CPT) codes or a description of each charge;
7. The date the Injury or Sickness began;
8. A statement indicating whether You are, or You are not, enrolled for coverage under any other health insurance plan or program. If You are enrolled for other coverage You must include the name of the other carrier(s), the name and date of birth of the subscriber for that coverage, and the Effective Date of the coverage.

### Claim Forms

Upon receipt of a notice of claim submitted within the time fixed in the Policy for filing proofs of loss below, We will furnish You claim forms for filing proofs of loss. If We do not furnish You a form within fifteen (15) days after receiving Your notice, You will be deemed to have complied with the requirements of this Policy. Your notice of claim should contain written proof covering the occurrence, the character and extent of the loss for which claim is made.

### Proof of Loss

Written proof of loss and notice of claim must be provided to Us within ninety (90) days after the date of such loss. Failure to furnish such proof within such time will neither invalidate nor reduce any claim if it was not reasonably possible to furnish such proof within such time. In no event, except in the absence of legal capacity of the claimant, will a claim be valid later than one (1) year from the time proof is otherwise required. All Benefits payable under this Policy will be payable not more than thirty (30) days after receipt of proof. Written proofs of claim must be furnished to the Plan at P. O. Box 4568, Springfield, MO 65808.

### Time of Payment of Claims

Eligible reimbursements payable under this Policy will be paid upon receipt of due written proof of such claim. All eligible reimbursement will be payable to Providers. We will send You an Explanation of Benefits form or letter. This will show You what services were paid, how much was paid, who was paid, when payment was made, or why payment for some services was not made or was made in part. There may be some circumstances for which We must seek additional information from You to process the claim. If this occurs, We will send You written notice within thirty (30) days after receipt of the claim. The notice will contain an explanation of the additional information that is required. We will suspend (pend) the claim until We receive the requested

information from You. If You present the information after the thirty (30) days allocated, the claim will be reprocessed in accordance to the terms and Benefits of Your coverage. If We deny all or any part of Your claim, We will send You an Explanation of Benefits form or a letter telling You why it was denied. The form or letter may also tell You what other information, if any, We would need to reconsider Our decision. If You do not agree with Our decision, You have the right to appeal Your claim. See Section 9 (Complaints and Appeals). You may also call or write Us, or You may contact the Arkansas Insurance Department.

### **Action on Claims**

If a claim is denied, We will send You a written notice that contains the reason for the denial and information on Your right to appeal. If You believe there is a discrepancy between the Benefits, this Policy, and the processing of such claim, or if You have a Grievance, You must notify the Plan no later than one-hundred and eighty (180) days from the date that written notice was sent from the Plan informing You of the event that gave rise to a Grievance. If a claim is denied, You may obtain a review of the denial through the Complaint and Grievance Procedure. See Section 8 (Complaints and Appeals).

### **Release of Records**

During the processing of Your claim, We might need to review Your health records. As a Covered Person, You hereby authorize the release to Us of all health records related to Your claim. This release constitutes authorization of any provision of law forbidding such disclosure. Your records will be maintained with strict confidentiality under the terms of applicable privacy laws. This authorization also applies to any Covered Dependent under this Policy.

### **Direct Payment to Public Hospitals**

Benefits for Covered Health Services will be paid, with or without an assignment from You, to public hospitals or clinics for services and supplies provided to You if proper claim is submitted by the public hospital or clinic. No Benefits will be paid under this Section to the public hospital or clinic, if such Benefits have been paid to You prior to Us receiving Your claim. Payment to the public hospital or clinic will discharge Us from all liability to You to the extent of the Benefits so paid.

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## Section 8: Coordinating Benefits with Other Coverage

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### When You have coverage under more than one plan

This section describes how Benefits under this Policy will be coordinated with those of any other plan that provides Benefits to You.

The order of Benefit determination rules below determine which plan will pay as the Primary Plan. The Primary Plan is the plan that pays first without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the Benefits it pays, so that payment from all plans do not exceed 100% of the Plan's Allowable Expenses.

### Definitions

For purposes of this section, terms are defined as follows:

#### ***Other (Another) Plan***

A Plan, or "other plan" is any of those which provides Benefits or services for, or because of, medical or dental care or treatment:

(1) Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

(2) Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act). Each contract or other arrangement for coverage under (1) or (2) is a separate plan. In addition, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

#### ***This Plan***

This Policy provides Benefits for individual health care expenses under Mercy Health Plans.

#### ***Primary Plan/Secondary Plan***

The order of benefit determination rules state whether this plan is a Primary Plan or Secondary Plan. When this plan is a Primary Plan, its Benefits are determined *before* those of the other plan, and without considering the other plan's Benefits. When this plan is a Secondary Plan, its Benefits are determined *after* those of the other plan, and may be reduced because of the other plan's Benefits.

#### ***Allowable Expense***

A necessary, customary and reasonable health care service or expense, including Copayments or Coinsurance that is covered, at least in part, by any of the Plans that provide Benefits to You. The difference between the cost of a private hospital room and the cost of a Semi-Private Room is not considered an Allowable Expense under this definition, unless the patient's stay in a private hospital room is medically necessary, either in terms of generally accepted medical practice or as specifically defined in the plan.

When a plan provides benefit in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid. When Benefits are reduced under a Primary Plan because You do not comply with the plan provisions, the amount of that reduction will not be considered an Allowable Expense. Examples of these provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements.

#### ***Claim determination period***

This period refers to a Calendar Year. However, it does not include any part of a year during which You have no coverage under this plan, or any part of a year before the date this COB provision or similar provision takes effect.

## General Information:

### When You have other health coverage

You must tell Us if You or a covered family member have coverage under any other health plan. This is called “double coverage.”

When You have double coverage, one plan normally pays its Benefits in full as the Primary payer and the other Plan pays a reduced benefit as the Secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

When We are the Primary payer, We will pay the Benefits described in this Policy.

When We are the Secondary payer, We will determine Our allowance. After the primary plan pays, We will pay what is left of Our allowance, up to Our regular benefit. We will not pay more than Our allowance.

### When other Government agencies are responsible for Your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

## Order of Benefit Determination Rules

**When coordination of benefits (COB) applies, the Order of Benefit Determination Rules should be looked at first.** These rules determine whether the Benefits of this Plan are determined before or after those of another Plan. The Benefits of this Plan:

- Will not be reduced when, under the order of benefit determination rules, this Plan is the Primary payer; but
- May be reduced when, under the order of benefit determination rules, this Plan is the Secondary payer. This reduction is described later in this section.

### General

When two or more Plans pay Benefits, the rules for determining the order of payment are as follows:

This Plan is a Secondary Plan, which has its Benefits determined after those of the other Plan, unless:

1. The other Plan has rules coordinating its Benefits with those of this Plan; and
2. Both those rules and this Plan's rules require that this Plan's Benefits be determined before those of the other Plan.

### Rules:

This plan determines its order of Benefits using the first of the following rules which applies:

#### 1. Nondependent / Dependent

The Plan that covers You as a Subscriber (other than as a Dependent, for example, as an employee or Member) is the Primary Plan.

The Benefits of the Primary Plan are determined *before* those of the Plan which covers You as a Dependent; **except**, if You are also a Medicare beneficiary and as a result of the rule established by Title XVII of the Social Security Act and implementing regulations, Medicare is:

- a) Secondary to the Plan covering You as a Dependent; and
- b) Primary to the Plan covering You as other than a Dependent (for example, a retired employee). The Benefits of the Plan covering You as a Dependent are determined before those of the Plan covering You as other than a Dependent.

#### 2. Dependent child whose parents are not separated or divorced

When this Plan and another Plan cover the same child as a Dependent, the order of Benefits is the “**Birthday Rule**” described below:

- The Primary Plan is the Plan of the parent whose birthday falls earlier in a year;
- If both parents have the same birthday, the Plan that covered either of the parents longer is Primary. However, if the other Plan does not have this rule (#2) and if, as a result, the Plans do not agree on the order of Benefits, the rule in the other Plan will determine the order of Benefits.

**Note:** The word, “birthday”, refers only to the month and day in a Calendar Year, not the year

in which the person was born.

- 3. Dependent child of unmarried (whether or not they ever have been married), separated, or divorced parents**

When this Plan and another Plan cover the same child as a Dependent of divorced or separated parents, Benefits for the child are determined in this order:

  - a) First, the Plan of the parent with custody of the child (*custodial parent*); then
  - b) The Plan of the Spouse of the parent with custody of the child (*Spouse of the custodial parent*); then
  - c) The plan of the parent not having custody of the child (*Non-custodial parent*).
  - d) However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. The Plan of the other parent will be the Secondary Plan. This rule applies to claim determination periods or plan years beginning after the Plan is given notice of the court decree.
- 4. Joint Custody**

If the specific terms of the court decree state that the parents will share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child will follow the "Birthday Rule" described above.
- 5. Active or inactive employee**

The Plan that covers You as an employee is Primary, if You are neither laid off nor retired. The same would hold true if You are a Dependent of a person covered as a retiree and an employee. If the other Plan does not have this rule and if, as a result, the plans do not agree on the order of Benefits, this rule (#5) is ignored.
- 6. Continuation coverage**

If Your coverage is provided under a right of continuation provided by Federal or state law, and You are also covered under another Plan, the Benefits of the Plan that covers You as an employee, retiree, Member or Subscriber (or as that person's Dependent) is Primary; and the continuation coverage is Secondary.

If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of the Benefits, this rule (#6) is ignored.
- 7. Longer/Shorter length of coverage**

If none of the previous rules determine the order of Benefits, the Benefits of the Plan that covered an employee, Member, Subscriber or retiree longer is Primary.

  - a) To determine length of time a person has been covered under a Plan, two Plans will be treated as one, if the Member was eligible under the second within twenty-four (24) hours after the first ended.
  - b) The start of a new Plan does not include
    - i. A change in the amount or scope of a Plan's Benefits;
    - ii. A change in the entry which pays, provides or administers the Plan's Benefits; or
    - iii. A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).
  - c) The length of time You are covered under a Plan is measured from Your first date of coverage under that Plan. If that date is not readily available, the date You first became a Member of the Plan will be used as the date from which to determine the length of time Your coverage under the present Plan has been in force.

### **Effect on the Benefits of this Plan When Plan is Secondary**

When this Plan is Secondary, We may reduce Your Benefits so that the total Benefits paid or provided by all Plans during a claim determination period are no more than 100% of total Allowable Expenses.

- a. **Reduction in this Plan's Benefits.** The Benefits of this Plan will be reduced when the sum of:
  - i. The Benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
  - ii. The Benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision (whether or not claim is made) exceeds those Allowable Expenses in a claim determination period. In that case, the Benefits of this plan will be reduced so that they and the Benefits payable under the other plans do not total more than those Allowable Expenses. When the Benefits of this plan are reduced as described previously, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

## **Coordinating Benefit Payments**

The Plan will make every effort to expedite the exchange of COB information required to process Your claim (s) under these COB provisions. Eligible reimbursements payable under this Policy will be paid upon receipt of due written proof of such claim and any additional information requested including COB information. Payment will be made within 30 days after receipt of a completed claim form. See "Time Payment of Claims" in Section 7 for more information.

## **Right to Receive and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under this Plan. We may get the facts We need from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under this Plan.

By accepting Coverage under this Policy, You agree to:

1. Provide this Plan with information about other coverage and promptly notify Us of any coverage changes;
2. Give Us the right to obtain information as needed from others to coordinate Benefits;
3. Return any excess amounts paid to You if the Plan or Your provider gives You a credit or payment and later finds that the other Plan's coverage should have been primary.

We need not tell, or get the consent of, any person to do this. Each person claiming Benefits under this Plan must give Us any facts We need to apply these rules and determine Benefits payable. If You do not provide Us the information We need to apply these rules and determine the Benefits payable, Your claim for Benefits will be denied.

## **Reconciliation of Payments**

A Primary payment made under another Plan may include an amount that should have been paid as Primary under this Plan. If this occurs, We may pay that amount to the organization that incorrectly made the payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount again. The term "payment made" includes providing Benefits in the form of services, in which case "payment made" means reasonable cash value of the Benefits provided in the form of services.

## **Right of Recovery**

If the amount of the payments We made is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. The person We have paid or for whom We have paid;
2. Insurance companies; or
3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any Benefits provided in the form of services.

## **Right of Reimbursement**

In consideration of the coverage provided by this Policy, We have the right to be reimbursed by You for the reasonable value of any services and Benefits We provide to You, from any or all of the following listed below:

- Third parties, including any person alleged to have caused You to suffer injuries or damages;
- Your employer;
- Any person or entity who is or may be obligated to provide Benefits or payments to You, including Benefits or payments for underinsured or uninsured motorist protection, no-fault traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), Workers' Compensation coverage, other insurance carriers or third party administrators;
- Any person or entity who is liable for payment to You on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties". You agree as follows:

- That You will cooperate with Us in protecting Our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - Providing any relevant information requested by Us,

- Signing and/or delivering such documents as We or Our agents reasonably request to secure the subrogation and reimbursement claim,
  - Responding to requests for information about any accident or injuries,
  - Making court appearances, and
  - Obtaining Our consent or Our agents' consent before releasing any party from liability or payment of medical expenses.
- That We have the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein;
  - That regardless of whether You have been fully compensated or made whole, We may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or a non-economic damage settlement or judgment;
  - That Benefits paid by Us may also be considered to be Benefits advanced;
  - That You will not accept any settlement that does not fully compensate or reimburse Us without Our written approval, nor will You do anything to prejudice Our rights under this provision;
  - That, upon Our request, You will assign to Us all rights of recovery against Third Parties, to the extent of the tortfeasors for whom You are seeking recovery, to be paid before any other of Your claims are paid;
  - That We may, at Our option, take necessary and appropriate action to preserve Our right under these subrogation provisions, including filing suit in Your name, which does not obligate Us in any way to pay Your part of any recovery We might obtain;
  - That We shall not be obligated in any way to pursue this right independently or on Your behalf.

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## Section 9: Complaints & Appeals

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These procedures address all Complaints and appeals from Members concerning operation of the Plan, except any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment.

A Member, a Member's authorized representative, or a provider can make a Complaint or appeal at any time. Complaints can be about anything, including: the Plan's service, Utilization Review, or a provider's service. A Complaint or appeal can always be directed to Arkansas Insurance Department at the following address and telephone number:

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, AR 72201  
(501) 371-2640, (800) 852-5494  
Fax: (501) 371-2749  
Email: [insurance.consumers@arkansas.gov](mailto:insurance.consumers@arkansas.gov)  
[www.insurance.arkansas.gov](http://www.insurance.arkansas.gov)

Step	Description
1	<p><b>What to do first. Contact Our Customer Contact Center. The telephone number is shown on Your ID card.</b></p> <p>Customer Contact Center Representatives are available to take Your call during regular business hours 8:00 a.m. – 5:00 p.m., Monday through Friday. At other times, You may leave a message on voicemail. A Customer Contact Center Representative will return Your call. If You would rather send Your Complaint to Us in writing at this point, You may write to Us at the address listed below.</p> <p>The Plan agrees to investigate and endeavor to resolve all complaints received from Members with regard to the nature of professional services rendered or Benefits provided under this Policy. Oral Complaints or inquiries can be made to the Plan by telephone or an arranged appointment with a Customer Contact Center Representative at:</p> <p>Mercy Health Plans ATTN: Customer Contact Center 14528 S. Outer 40, Suite 300 Chesterfield, Missouri 63017-5743 (314) 214-2380 or (866) 785-5849</p> <p>The Customer Contact Center Representative will make every effort to resolve the concern to Your satisfaction during the initial telephone call or interview with the Plan. Resolution of Complaints through this process will not preclude Your rightful access to review through the formal appeal Process.</p>
2	<p><b>Expedited Appeal Procedure</b> When the standard time frames in the Complaint and appeal procedures would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum function, a request for an expedited review can be submitted. An expedited review request may be made verbally or in writing. A decision will be made within seventy-two (72) hours after receiving a request for an expedited review. This will be followed by written notification of that decision within three (3) calendar days of the notification of the determination.</p>
3	<p><b>Ask Us for an External Independent Review, only if Your appeal was related to an Adverse Determination.</b></p> <p>Within sixty (60) days of the date You or Your authorized representative receive written notice of an Adverse Determination, You or Your authorized representative may initiate an External Review. A request for a standard External Review must be made in writing or via electronic media, and should include any information or documentation to support Your request for the covered service.</p>

Note: Only appeals that are related to an Adverse Determination and that involve treatment, services, equipment, supplies, or drugs that would require the health benefit plan to expend five hundred dollars (\$500) or more of expenditures are

afforded an external independent review.

**“Adverse Determination”** means a determination by the Plan that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

- The requested health care service does not meet the health benefit plan's requirements for medical necessity, or
- The requested health care service has been found to be "experimental/investigational."

The Plan will select an independent review organization from a list of independent review organizations approved by the Arkansas Insurance Department. The Plan shall be solely responsible for paying the fees of the external independent review organization selected to perform the review. For the purposes of this Section, an external Independent Reviewer shall: (a) be a clinical peer; (b) have no direct financial interest in connection with the case; and (c) not have been informed of the specific identity of the Member.

The independent review organization will complete its review within forty-five (45) calendar days after the receipt of the request for an External Review and will provide a written notice of its decision to You or Your authorized representative, Your attending Physician and the Plan.

An expedited external independent review may be requested for a situation when a delay would significantly increase the risk to Your health or when extended health care services for a course of treatment that You are undergoing is at issue. Upon submission of a request for expedited external independent review, the Plan will immediately assign an independent review organization approved by the Arkansas Insurance Department. The independent review organization shall make a determination and verbally notify You, Your authorized representative, Your attending Physician and the Plan of its decision within seventy-two (72) hours after receipt of all necessary information. The decision by the Independent Reviewer is final. Within two (2) days, the independent review organization will follow up with a written notice of the determination via mail.

Nothing in this Section shall be construed to require the Plan to pay for a health care service not covered under this Policy.

**If You are dissatisfied with Our decision,** At any time, You have the right to contact the Arkansas Insurance Department's consumer complaint hotline at: 1-800-852-5494 regarding Your appeal, or write to the Arkansas Insurance Department at the following address:

**Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street, Little Rock, AR 72201.**

## **Appeal Decisions**

You will receive a decision from the Plan within the timeframes set forth above for an appeal. The decision will be provided in writing. However, in the case of an Expedited appeal, the decision will be provided verbally and written notification is provided within three (3) calendar days after the verbal notification. Any denial of Your appeal will contain the following information:

1. The specific reason or reasons for the denial;
2. Reference to the specific Plan provisions on which the denial is based;
3. A statement that You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to Your claim for Benefits;
4. A statement that You or Your authorized representative can request an External Review of an Adverse Determination and the procedures for obtaining an External Review.
5. A statement of Your right to bring a civil action under ERISA;
6. Any specific guideline that was relied upon in issuing the denial, or a statement that such guideline will be provided to You free of charge upon request;
7. If the denial is based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to Your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
8. The following statement: "You and Your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency."

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## Section 10: Utilization Review

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The following is information pertaining to utilization review decisions and procedures. Please note that in addition to utilization reviews, Mercy Health Plans practices care management and therefore may provide You with information about additional services that are available to You, such as disease management programs, health education, pre-admission counseling and patient advocacy.

### Initial Determinations

For initial determinations, the Plan will make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

In the case of a determination to certify an admission, procedure or service, the Plan will notify the provider rendering the service by telephone within twenty-four (24) hours of making the initial certification.

In the case of an Adverse Determination, the Plan will notify the provider rendering the service by telephone within twenty-four (24) hours of making the Adverse Determination; and will provide written or electronic confirmation of the telephone notification to You and Your provider within one (1) working day of making the Adverse Determination.

### Concurrent Review Determinations

For concurrent review determinations, the Plan will make the determination within one (1) working day of obtaining all necessary information.

In the case of a determination to certify an extended stay or additional services, the Plan will notify by telephone the provider rendering the service within one (1) working day of making the certification.

In the case of an Adverse Determination, the Plan will notify by telephone the provider rendering the services within twenty-four (24) hours of making the Adverse Determination, and provide written or electronic notification to You and Your provider within one (1) working day of the telephone notification. The services will be continued without liability to You until You have been notified of the determination.

### Retrospective Review Determinations

For retrospective review determinations, the Plan will make the determination within thirty (30) working days of receiving all necessary information. The Plan will provide notice in writing of Our determination to You within ten (10) working days of making the determination.

### Adverse Determination

A written notification of an Adverse Determination will include the principal reason or reasons for the determination, the instructions for initiating an appeal or reconsideration of the determination, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination, and notice of Your right to External Review. The Plan will provide the clinical rationale in writing for an Adverse Determination, including the clinical review criteria used to make that determination, to any party who received notice of the Adverse Determination and who requests such information.

### Reconsideration of an Adverse Determination

In a case involving an initial determination or a concurrent review determination, the Plan will give the provider rendering the service an opportunity to request on Your behalf a reconsideration of an Adverse Determination by the reviewer making the Adverse Determination.

The reconsideration will occur within one (1) working day of the receipt of the request and will be conducted between the provider rendering the service and the reviewer who made the Adverse Determination, or a clinical peer designated by the reviewer who made the Adverse Determination (if the reviewer who made the Adverse Determination is not available within one (1) working day).

If the reconsideration process does not resolve the difference of opinion, You or Your provider may appeal the Adverse Determination. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an Adverse Determination.

**Lack of Information**

The Plan will have written procedures to address failure or inability of a provider or an enrollee to provide all necessary Information for review. In cases where the provider or an enrollee will not release necessary information, the Plan may deny certification of an admission, procedure or service.

**Complaint and Grievance Procedures**

These procedures address all Complaints and appeals concerning operation of Mercy Health Plans except any Complaints that allege or indicate possible professional liability. These procedures are designed to provide timely, thorough and fair review of determinations in utilization management and claims payment. The Grievance procedure is more fully described in Section 9 (Complaints and Appeals).

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## Section 11: General Provisions

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### Your Relationship with Us

In order to make choices about Your health care coverage and treatment, We believe that it is important for You to understand how We interact with You. We help finance and administer the benefit plan in which You are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to You decisions about whether Your benefit plan will cover or pay for the health care that You may receive. The plan pays for certain medical costs, which are more fully described in this Policy. The plan may not pay for all treatments You or Your Physician may believe are necessary. If the plan does not pay, You will be responsible for the cost.
- We do not decide what care You need or will receive. You and Your Physician make those decisions.

We may use individually identifiable information about You to share with You (and You alone) procedures, products or services that You may find valuable. We will use individually identifiable information about You as permitted or required by law, in Our operations and in Our research. We will use de-identified data for commercial purposes including research.

If any provision(s) of this Policy conflicts with the Arkansas law, then those provision(s) are automatically changed to conform to at least the minimum requirements of the law.

### Our Relationship with You

The relationship between You and the Plan is solely a contractual relationship between independent contractors. You are not Our agent or employee. Neither We nor any of Our employees are Your agents.

We do not provide Health Care Services or supplies, nor do We practice medicine. We are **not** liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of Benefits under Your benefit plan.

You are solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in Your enrollment or the termination of Your coverage);
- The timely payment of the required Premium to Us.

### Your Relationship with Providers

Your relationship with Your physician and other health care providers are important You. You have the right and responsibility to take part in all choices about Your health care and to be involved in decisions about Your treatments.

You have a right to get accurate, easy-to-understand information to help You make good choices about Your doctors, hospitals, and other providers.

You have a right to know how providers are paid. This includes the types of services the Provider will perform and any associated charges that You may incur. In particular, if Your Provider refers You to another Provider or prescribes tests and treatment outside of his/her office. You should verify the nature and cost of those services, whether the other Provider is a Network or Non-Network Provider, and any billing practices and method of payment that might be required.

At times, ancillary providers such as Radiologists, Anesthesiologists and Pathologists (to name a few) may participate in Your care. You should inquire if Providers such as these will be used in Your care, whether the Provider participates in Our Network, and what responsibility You will have for charges incurred when those Providers bill for that care.

You have a responsibility to pay Your Deductibles, Co-payments, and Coinsurance, as well as charges for non-covered services in a timely manner.

## **Administrative Services**

We may, in Our sole discretion, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in Our sole discretion. We are not required to give You prior notice of any such change, nor are We required to obtain Your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

## **Amendments to this Policy**

To the extent permitted by law, We reserve the right, in Our sole discretion and without Your approval, to change, interpret, modify, withdraw or add Benefits or terminate this Policy.

Any provision of this Policy that on its Effective Date is in conflict with the requirements of state or Federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider that has been signed by one of Our officers. All of the following conditions apply:

- Amendments to this Policy are effective thirty-one (31) days after We send a written notice to the Enrolling Individual;
- Riders are effective on the date We specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

## **Assignment**

This Policy and all the rights, responsibilities and benefit payments under it are personal to You. You may assign them to any Provider of Covered Service.

## **Case Management**

Case Management is a service that assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible, whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending physician to determine appropriate treatment options that will best meet the patient's needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, oncology, mental health, rehabilitation or general medicine and surgery. A case manager trained in the appropriate clinical specialty area will be assigned to You or Your covered Dependent. In addition, case managers are supported by a panel of physician advisors, who offer guidance on up-to-date treatment programs and medical technology. While the case manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending physician remains responsible for the actual medical care.

## **Clerical Error**

If a clerical error or other mistake occurs, that error will not deprive You of Benefits under this Policy, nor will it create a right to Benefits. If the Enrolling Individual makes a clerical error (including, but not limited to, sending Us inaccurate information regarding Your enrollment for coverage or the termination of Your coverage under this Policy) We will not make retroactive adjustments beyond a sixty (60) day time period.

## **Conformity with State Laws**

If any provision (s) of this Policy conflicts with the Arkansas law, then those provision(s) are automatically changed to conform to at least the minimum requirements of the law.

## **Commission or Omission**

No Hospital, Physician or other Provider of service will be liable for any act of commission or omission by Us. We will not be liable for any act of commission or omission by (1) any Hospital or Hospital's agent or employee; (2) any Physician or Physician's agent or employee; (3) any other Providers or services or their agent or employee; or (4) You.

## **Entire Policy/Changes**

This Policy issued to You, Your application, Amendments and Riders constitute the entire Policy. No change in this Policy will be valid until approved by one of Our executive officers and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Policy or waive any of its provisions.

## **Examination of Covered Persons**

In the event of a question or dispute regarding Your right to Benefits, We may require that a Network Physician of Our choice examine You at Our expense.

## **Incentives to You**

Sometimes We may offer coupons or other incentives to encourage You to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone, but We recommend that You discuss participating in such programs with Your Physician. These incentives are not Benefits and do not alter or affect Your Benefits. Contact Us if You have any questions.

## **Incorporation by Reference**

Unless otherwise stated therein, the Schedule of Coverage and Benefits, the schedule of rates and Premiums, any riders, the application, and any amendments to any of the foregoing, form a part of this Policy as if fully incorporated herein.

## **Information and Records**

At times, We may need additional information from You. You agree to furnish Us with all information and proofs that We may reasonably require regarding any matters pertaining to this Policy. If You do not provide this information when requested, it may delay or deny payment of Your Benefits.

By accepting Benefits under this Policy, You authorize and direct any person or institution that has provided services to You to furnish Us with all information or copies of records relating to the services provided to You. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents, whether or not they have signed the Subscriber's application form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning Health Care Services that are necessary to implement and administer the terms of this Policy for appropriate medical review, quality assessment, or as We are required to do by law or regulation. During and after the term of this Policy, We and Our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of Your medical records or billing statements We recommend that You contact Your health care provider. Providers may charge You reasonable fees to cover their costs for providing records or completing requested forms.

If You request medical forms or records from Us, We also may charge You reasonable fees to cover costs for completing the forms or providing the records.

In some cases, We will designate other persons or entities to request records or information from or related to You, and to release those records as necessary. Our designees have the same rights to this information as We have.

You will give Us information reasonably necessary to maintain Your records on a current basis. Failure to provide such information may terminate this Policy. Our clerical errors or delays in keeping or reporting data relative to coverage will not terminate coverage which would otherwise be in force, nor continue coverage which would otherwise be terminated. Upon discovery of errors or delays, We will make whatever change is needed to assure that You have the coverage to which You are entitled to. No retroactive coverage or Premium changes will be made unless prior written approval is received from Us. Retroactive changes beyond sixty (60) days will

not be approved unless We are at fault.

## **Interpretation of Eligibility and Benefits**

Mercy Health Plans (MHP) has sole discretion to do all of the following:

- Determine eligibility;
- Interpret Benefits under the Policy;

. This function is the responsibility of MHP. We may delegate this authority to other persons or entities that provide services in regards to the administration of this Policy. Note: You have the right to appeal the decision, file a Grievance, seek relief through the Department of Insurance, or seek legal action to enforce the contract.

In certain circumstances, for purposes of overall cost savings or efficiency, We may, in Our sole discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that We do so in any particular case will not in any way be deemed to require Us to do so in other similar cases.

## **Legal Actions**

You may not bring any action of law or in equity concerning a claims payment until sixty (60) days after written proof of claim for Benefit payment has been furnished to Us in accordance with the requirement of this Policy. Any such action must be filed within three (3) years of the date a claim is required to be sent to Us.

## **Medicare Eligibility**

Benefits under this Policy are not intended to supplement any coverage provided by Medicare. Covered Persons who are eligible for or enrolled in Medicare may NOT be covered under the Policy.

## **Misstatement of age**

If the age of the insured has been misstated, all amounts payable under this Policy shall be equal to the amount that the Premium paid would have been, if purchased at the actual age when the policy was issued.

## **Notice**

When We provide written notice regarding administration of this Policy to Your authorized representative, that notice is deemed notice to You and Your Enrolled Dependents.

Any notice required by or given under this Policy may be given by United States Mail, first class, or postage prepaid, address as follows:

- (a) To You, when addressed to You at the address currently appearing on Our records;  
To Mercy Health Plans, when addressed to First Security Center, 521 President Clinton Avenue, Suite 700, Little Rock, Arkansas 72201.  
If We provide You written notice, it will be mailed to the last address specified in the corporate records of Mercy Health Plans.

## **Policies, Identification Cards and Applications**

We will furnish You with identification cards, copies of this Policy, and applications.

## **Reimbursement to Us**

- a)As a Covered Person, You agree to refund Us any benefit payment We made to You or on Your behalf for a claim paid or payable under Workers' Compensation or employers' liability law. Even if You fail to claim through a Workers' Compensation or employers' liability law and You could have received payment through such a law if You had filed, reimbursement must still be made to Us. We have the right to credit payments of such claims against future claims in all cases.

b)We have the right to correct benefit payments paid in error. Hospitals, Physicians, other Providers and/or You have the responsibility to return any overpayment including claims made involving fraud to Us. We have the responsibility to make additional payment if an underpayment is made.

### **Statements by Enrolling Individual or Subscriber**

Except for fraudulent statements, all statements made by the Enrolling Individual or Subscriber will be deemed representations and not warranties and that no statement made for the purpose of effecting insurance shall void the insurance or reduce benefits, unless contained in a written instrument signed by the policyholder of the insured person, a copy of which has been furnished to the policyholder or to the person or his or her beneficiary.

### **Time Limit on Certain Defenses**

1. After three (3) years from the date of issue of this Policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Policy shall be used to void this Policy or to deny a claim for charges incurred after the expiration of such three (3) year period.
2. The time limits of this Policy for charges incurred due to a Preexisting Condition, if applicable, are set forth in Section 13 (M).

### **Workers' Compensation not Affected**

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by Workers' Compensation insurance.

## Section 12: Covered Benefits

Benefit	Description
<p style="text-align: center;"><b>See Schedule of Coverage and Benefits for Your cost-sharing Amount</b></p> <p style="text-align: center;">Note: Copayments do not count towards Your Out-of-Pocket (OOP) Maximum; only Deductibles and Coinsurances apply to Your OOP Maximum.</p>	
1. Allergy Services	<ul style="list-style-type: none"> <li>• Office visits</li> <li>• Injections and serum, treatment, or testing (when no charge is made for physician services)</li> </ul>
2. Ambulance Services- Emergency Only	<p>Medically Necessary ambulance service (either by a licensed ambulance service - ground or air ambulance) to the most appropriate Hospital where Emergency Care can be provided in the case of a Medical Emergency Condition; however, use of air ambulance must be approved in advance or as soon as reasonably possible by the Plan. Ambulance services do not include safety evacuation or medical transportation from foreign countries, even in Emergency situations. See Section 13, R., for related exclusions.</p>
3. Dental -Anesthesia and Facility Charges	<p>Administration of general anesthesia and Hospital charges for dental care if:</p> <ul style="list-style-type: none"> <li>• The Covered Person is a child under the age of seven (7) who is determined by two (2) licensed dentists to require, without delay, necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition; or</li> <li>• The Covered Person is diagnosed with a serious mental or physical condition; or</li> <li>• The Covered Person has a significant behavioral problem as determined by the Covered Person's Physician.</li> </ul> <p>Limitations and Exclusions are described in Section 13, C.</p> <p style="text-align: center;"><b><u>Prior Authorization Required</u></b></p> <p>Unless We pre-approve these services, Network and Non-Network Benefits for dental anesthesia and related facility charges will be reduced by 50% of Eligible Expenses.</p>
4. Dental Services - Accident only	<p>Dental services when all of the following are true:</p> <ul style="list-style-type: none"> <li>• Treatment is necessary because of accidental damage</li> <li>• Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D."</li> <li>• The dental damage is severe enough that initial contact with a Physician or dentist occurred within seventy-two (72) hours of the accident</li> </ul> <p>Benefits are available only for treatment of a sound, natural tooth. Sound, natural teeth means teeth and tissue that are viable, functional, and free of disease. The Physician or dentist must certify that the injured tooth was:</p> <ul style="list-style-type: none"> <li>• A virgin or unrestored tooth</li> <li>• A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.</li> </ul> <p>Dental services for final treatment to repair the damage must be completed within the timeframe described in Your Schedule of Coverage and Benefits. Dental x-rays and narrative report for independent dental consultant review may be required.</p> <p>Coverage does not include Benefits for the repair or replacement of dental prosthetics, including but not limited to bridges, dentures, crowns, implants, braces, and retainers. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth other than for normal biting or chewing is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities, or specifically excluded in Section 13, C.</p>

Benefit	Description
	<p align="center"><b>See Schedule of Coverage and Benefits for Your cost-sharing Amount</b></p> <p align="center">Note: Copayments do not count towards Your Out-of-Pocket (OOP) Maximum; only Deductibles and Coinsurances apply to Your OOP Maximum.</p>
	<p align="center"><b><u>Prior Authorization Required</u></b></p>
<p><b>5. Diabetes Services</b></p>	<p>You do not have to notify Us before the initial Emergency treatment. However, You must obtain Prior Authorization as soon as possible and before follow-up (post-Emergency treatment) begins. Unless We pre-approve post-emergency treatment, coverage for accidental dental services will be reduced by 50% of Eligible Expenses.</p> <p>Medically appropriate and necessary equipment, supplies and self-management training for the management and treatment of diabetes. Services are provided for persons with gestational, type I or type II diabetes.</p> <p>Coverage is provided for insulin infusion devices, insulin pumps, and associated supplies.</p> <p>Services for <b>diabetes self-management training</b>: Covered Health Services are limited to a program that complies with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association. Diabetes self-management training shall be provided only upon prescription by a licensed physician and a licensed health care professional must certify that the Covered Person successfully completed the training program.</p> <p>Coverage is limited to one (1) program during the entire time a Covered Person is Covered under this Certificate. However, a Physician may prescribe additional training, due to a significant change in the Covered Person's symptoms or condition.</p> <p>A provider licensed, registered, and/or certified in the state to provide appropriate Health Care Services must provide diabetes self-management training program. Training is to be provided upon the initial diagnosis of diabetes, where there is a significant change in the Member's symptoms and when the Food and Drug Administration for the treatment of diabetes approve new techniques and treatments.</p>
	<p align="center"><b><u>Prior Authorization Required</u></b></p>
	<p>You must obtain Prior Authorization before receiving services for insulin pumps. Diabetes services are not subject to any durable medical equipment (DME) limits. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses</p>
<p><b>6. Dialysis</b></p>	<p>Medically Necessary dialysis is a covered Benefit.</p>
<p><b>7. Durable Medical (DME) and Medical Supplies</b></p>	<p><b><u>Durable Medical Equipment (DME)</u></b> and its associated supplies that meet each of the following criteria:</p> <ul style="list-style-type: none"> <li>• Ordered or provided by a Physician for outpatient use;</li> <li>• Standard Basic Hospital-type Equipment that meets the medical need;</li> <li>• It can withstand repeated use;</li> <li>• Used for medical purposes;</li> <li>• Not consumable or disposable;</li> <li>• Not of use to a person in the absence of a disease or disability;</li> <li>• It is not primarily a device for enhancing the environmental setting in which the patient is placed or altering air quality or temperature;</li> <li>• It is not used for exercising or training; and</li> <li>• It is not used for monitoring health conditions.</li> </ul> <p>If more than one piece of Standard Basic Hospital-type Equipment can meet Your functional needs, Benefits are available only for the most cost effective piece of equipment.</p> <p>Examples of DME include:</p> <ul style="list-style-type: none"> <li>• Equipment to assist mobility, such as a standard wheelchair.</li> <li>• A standard Hospital-type bed.</li> <li>• Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks.)</li> </ul>

**Benefit****Description****See Schedule of Coverage and Benefits for Your cost-sharing Amount**

Note: Copayments do not count towards Your Out-of-Pocket (OOP) Maximum; only Deductibles and Coinsurances apply to Your OOP Maximum.

We will decide if the equipment should be purchased or rented. If more than one piece of Standard Basic Hospital-type Equipment can meet Your functional needs, Benefits are available only for the most cost effective piece of equipment. DME is not modified, repaired, or replaced unless necessitated by the Member's medical condition. The Plan may replace an item because of severe damage or loss through no intentional act of the Member; however, an item is generally not replaced more than once per [Calendar] [Rolling] [Plan] Year. Please note that any DME limitation is not applicable to any equipment, supplies or self-management training for the treatment of diabetes. In no event shall orthodontic braces, humidifiers, air conditioners, dehumidifiers or similar personal comfort items be treated as DME for purposes of this Plan. See Section 13, B. and G., for information on medical supplies and equipment that We do not cover.

**Prior Authorization Required**

We must pre-approve any single item of DME that costs more than \$1,000 (either purchase price or cumulative rental of a single item). Unless We pre-approve services over \$1,000, You will be responsible for paying 100% of the charges and no Benefits will be paid.

***Medical Supplies***

Coverage includes Medically Necessary supplies only when prescribed by a Physician and supplied by a home care agency in conjunction with covered home health care services, or when dispensed and used by a Network Provider in conjunction with treatment of the member. The following medical supplies are covered:

- Diabetic supplies (see *Diabetes Services* above);
- Standard ostomy supplies;
- Catheters (urinary and respiratory) and associated supplies such as drainage bags and irrigation kits;
- Sterile surgical wound supplies;
- Jobst stockings or other support hose ordered by a physician and determined to be Medically Necessary, but only two (2) support stockings per [Calendar] [Plan] Year are covered.

Coverage of medical supplies does not include items usually stocked in the home for general usage such as bandages, thermometers and petroleum jelly. Supplies that can be purchased over the counter without a physician's order are not covered. See Section 13, C., H., for related limitations and exclusions.

**[Prior Authorization Required]**

Some medical supply services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at [www.mercyhealthplan.com](http://www.mercyhealthplan.com) or by calling Our Customer Contact Center at the number listed on Your ID card. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by [50% - 100%] of Eligible Expenses].

**8. Emergency Room Services**

Emergency Room Services that are required to stabilize or initiate treatment in an Emergency. Emergency Room Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in Section 4 (How You Get Care).

Please remember that if You are admitted to a Hospital as a result of an Emergency, You must notify Us within two (2) business days or the same day of admission, or as soon as reasonably possible to receive authorization for continued services related to post-stabilization as needed. If You don't notify Us, Benefits for the Hospital Inpatient Stay will be reduced by 50% of Eligible Expenses. Benefits will not be reduced for the outpatient Emergency Room Services. Please refer to *Inpatient Hospital Services* below.

If an Emergency Room admission results in a conversion to an Inpatient Stay or Observation Care for the same condition within 24 hours, the Emergency Room Copayment/Coinsurance will be waived. The alternate higher level Copayment/Coinsurance will apply.

Benefit	Description
<p align="center"><b>See Schedule of Coverage and Benefits for Your cost-sharing Amount</b></p> <p align="center">Note: Copayments do not count towards Your Out-of-Pocket (OOP) Maximum; only Deductibles and Coinsurances apply to Your OOP Maximum.</p>	
<b>9. Eye Examinations (Routine Only)</b>	<p>Expenses for one (1) routine eye examinations per [Calendar] [Rolling] [Plan] Year by an Ophthalmologist or Optometrist at the frequency listed in Your Schedule of Coverage and Benefits.</p> <p>Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses. See Section 13, S., for more information on limitations and exclusions related to vision care.</p>
<b>10. Hearing Aids</b>	<p>Members are entitled to coverage for up to one (1) non-digital (analog), programmable hearing aid per ear every [three (3) [Rolling] [Plan] [Calendar] Years] [thirty-six (36) consecutive months]. Members may apply the “standard benefit” towards the purchase of additional functionality (i.e., digital). Coverage is provided for behind the ear (BTE) or in the ear (ITE) hearing aids and includes associated hearing aid fitting/dispensing fees. Members are responsible for any additional charges for functionality enhancements and/or components.</p> <p>Members shall be entitled to a total maximum Benefit of \$1,400 per ear net expense applicable toward the purchase, repair of hearing aids and replacement parts every [three (3) [Rolling][Calendar][Plan] Years][thirty-six (36) consecutive months].</p> <p>Coverage of hearing aids is not subject to any Deductible, Coinsurance or Copayment.</p> <p>Hearing Testing: Specialist Copayment for annual hearing test will apply. If hearing test is done in conjunction with an office visit, only one Copayment applies.</p> <p>Exclusions are described in Section 13, P.</p>
<b>11. Home Health Care</b>	<p>Services received from a Home Health Agency that are:</p> <ul style="list-style-type: none"> <li>• Ordered by a physician;</li> <li>• Provided by or supervised by a registered nurse in Your home; and</li> <li>• You are Homebound or Your physical or mental condition poses a serious and significant impediment to receiving medically necessary services outside the home.</li> </ul> <p>Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:</p> <ul style="list-style-type: none"> <li>• It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.</li> <li>• It is ordered by a Physician.</li> <li>• It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair.</li> <li>• It requires clinical training in order to be delivered safely and effectively.</li> <li>• It is not Custodial Care.</li> </ul> <p>We will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed Medical management. A service will not be determined to be “skilled” simply because there is not an available caregiver.</p> <p>Certain extended home infusion services may be more appropriately performed in the home even if You are not Homebound. Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication are excluded. See Section 13, J. for related exclusions.</p>

**Prior Authorization Required**

Unless We pre-approve home health services, Network and Non-Network Benefits will be

Benefit	Description
See Schedule of Coverage and Benefits for Your cost-sharing Amount	
Note: Copayments do not count towards Your Out-of-Pocket (OOP) Maximum; only Deductibles and Coinsurances apply to Your OOP Maximum.	
reduced by 50% of Eligible Expenses.	
12. Hospice/Palliative Care	<p>Hospice/Palliative care that is recommended by a Physician. Hospice/Palliative care is an integrated program that provides comfort and support services for the terminally ill. An individual is considered to be terminally ill if the medical prognosis for the life expectancy of that individual is six (6) months or less. A written or oral certification of the terminal illness must be provided to the hospice agency no later than two (2) calendar days after hospice care is initiated.</p> <p>Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Services can be provided either on an inpatient or on an outpatient basis. Benefits are available when hospice care is received from a licensed hospice agency.</p> <p>Discharge from a hospice may occur because You:</p> <ul style="list-style-type: none"><li>• Revoke the hospice benefit;</li><li>• Move away from the geographic area serviced by the hospice agency;</li><li>• Transfer to another hospice;</li><li>• Your condition improves and You are no longer considered terminally ill; or</li><li>• You are deceased.</li></ul> <p>Please contact Us for more information regarding Our guidelines for hospice care. You can contact Us at the telephone number on Your ID card.</p> <p>Any combination of Network and Non-Network Benefits is limited to one hundred and eighty (180) days during the entire period of time You are covered under this Policy.</p> <p><b><u>Prior Authorization Required</u></b></p> <p>Unless We pre-approve hospice/palliative care services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.</p>
13. Immunizations - Routine Only	<p>Routine immunizations as defined by the Plan. Coverage limitations may apply but only for adults over eighteen (18) years of age. Immunizations required for international travel are excluded. A list of routine immunizations can be obtained at <a href="http://www.mercyhealthplans.com">www.mercyhealthplans.com</a> or by calling Our Customer Contact Center at the number listed on Your ID card.</p>
14. Injectables/Infusions	<p>Benefits are available for injections/infusions received in a Physician's office, infusion center or through home health. Some injectables and infusions received in the locations listed above may incur additional member responsibility for the injectable/infusion, in addition to any cost-sharing for the Physician's office visit, infusion center or home health service, regardless of whether other health services are received.</p> <p><b><u>Prior Authorization Required</u></b></p> <p>Some injectables/infusions require Prior Authorization. A list of injectables/infusions requiring Prior Authorization can be obtained at <a href="http://www.mercyhealthplans.com">www.mercyhealthplans.com</a> or by calling Our Customer Contact Center at the number listed on Your ID card. Unless We pre-approve injectable/infusions that require Prior Authorization, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.</p>
15. Inpatient Hospital Services	<p>Inpatient Stay in a Hospital. Benefits are available for:</p> <ul style="list-style-type: none"><li>• Services and supplies received during the Inpatient Stay.</li><li>• Room and board in a Semi-Private Room (a room with two or more beds), or</li><li>• A private room only when medically necessary and approved in advance by the Plan.</li></ul> <p><b><u>Prior Authorization Required</u></b></p> <p>Please remember that You must notify Us as follows:</p>

Benefit	Description
<b>See Schedule of Coverage and Benefits for Your cost-sharing Amount</b>	
Note: Copayments do not count towards Your Out-of-Pocket (OOP) Maximum; only Deductibles and Coinsurances apply to Your OOP Maximum.	
<b>16. Mental Health and Substance Abuse Services - Outpatient</b>	<ul style="list-style-type: none"> <li>• For elective admissions; and</li> <li>• For Emergency admissions: within two (2) business days or the same day of admission, or as soon as is reasonably possible.</li> </ul> <p>Unless We pre-approve inpatient Hospital services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.</p>
	<p>Mental Health, Substance Abuse and a Chemical Dependency evaluations and assessment prescribed by a licensed professional.</p> <ul style="list-style-type: none"> <li>• Diagnosis</li> <li>• Treatment planning</li> <li>• Referral services</li> <li>• Medication management</li> <li>• Short-term individual, family and group therapeutic services (including Intensive Outpatient Program)</li> <li>• Crisis intervention</li> </ul> <p>For Network Benefits, referrals to a mental health/substance abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordinating all of Your care. Contact the Mental Health/Substance Abuse Designee regarding Network Benefits for outpatient Mental Health and Substance Abuse Services.</p> <p>Any combination of Network and Non-Network Benefits for these outpatient Mental Health Services and/or Substance Abuse Services is limited according to Your Schedule of Coverage and Benefits. See Section 13, H., P. for exclusions related to this Benefit.</p>
<b><u>Prior Authorization Required</u></b>	
<b>17. Mental Health and Substance Abuse Services – Inpatient and Intermediate</b>	<p>Please remember that You must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health / Substance Abuse Designee phone number appears on Your ID card. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.</p>
	<p>Mental Health and Substance Abuse Services received on an inpatient or intermediate care basis in a Hospital or an Alternate Facility. Benefits include detoxification from abusive chemical or substances that is limited to physical detoxification when necessary to protect Your physical health and well-being.</p> <p>The Mental Health/Substance Abuse Designee, who will arrange for the service, will determine the appropriate setting for the treatment. If an Inpatient Stay is required, it is covered on a Semi-Private Room basis. At the discretion of the Mental Health/Substance Abuse Designee, two (2) sessions of intermediate care (such as Partial Hospital Treatment Program) may be substituted for one (1) inpatient day.</p> <p>Network Benefits for Mental Health Services and Substance Abuse Services must be provided by or under the direction of the Mental Health/Substance Abuse Designee. For Network Benefits, referrals to a mental health/substance abuse provider are at the sole discretion of the Mental Health/Substance Abuse Designee, who is responsible for coordination all of Your care. Contact the Mental Health/Substance Abuse Designee regarding Benefits for inpatient/intermediate Mental Health Services and Substance Abuse Services.</p> <p>Any combination of Network and Non-Network Benefits for these inpatient and intermediate Mental Health Services and Substance Abuse is limited according to Your Schedule of Coverage and Benefits. Residential treatment services are not covered. See Section 13, H., P. for exclusions related to this Benefit.</p>

Benefit	Description
<b>See Schedule of Coverage and Benefits for Your cost-sharing Amount</b>	
Note: Copayments do not count towards Your Out-of-Pocket (OOP) Maximum; only Deductibles and Coinsurances apply to Your OOP Maximum.	
<b><u>Prior Authorization Required</u></b>	
Please remember that You must call and get authorization to receive these Benefits in advance of any treatment through the Mental Health/Substance Abuse Designee. The Mental Health / Substance Abuse Designee phone number appears on Your ID card. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.	
<b>18. Newborn Child Coverage</b>	Coverage for newborn children begins from the moment of birth. Benefits include coverage for illness, injury, congenital defects, premature birth, tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, all other disorders of metabolism, and routine nursery care and pediatric charges for a well newborn child for up to five (5) full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period.
<b><u>Prior Authorization Required</u></b>	
We must be notified within ninety (90) days of birth, or Your next Premium due date, whichever is greater. If You don't notify Us, You will be responsible for paying 100% of the charges incurred after the lesser of five (5) days, or the mother's discharge date.	
<b>19. Nutritional Counseling</b>	Nutritional counseling that is appropriately included as part of the course of treatment based on the efficacy of the diet and lifestyle and treatment of the disease states, in accordance with Plan policies and procedures, which are subject to change. Expenses for nutritional counseling for up to three (3) visits in a [Calendar] [Plan] Year are covered. Coverage is provided for only certain conditions such as diabetic education, congestive heart failure, malnutrition and nutritional deficiencies. See Section 13, I. and K., for related limitations or exclusions to this benefit.
<b>20. Observation Care</b>	<p>Observation Care are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the Hospital as an inpatient.</p> <p>Most Observation services do not exceed one (1) day. Some patients, however, may require a second day of outpatient Observation services. Members may be admitted as Observation status to beds in the Emergency room, an Observation unit, the intensive care unit, or a regular floor. If an Observation admission results in a conversion to an Inpatient Admission for the same condition within 24 hours, the Observation Copayment/Coinsurance will be waived. The alternate Copayment/Coinsurance will apply.</p>
<b><u>Prior Authorization Required</u></b>	
Unless We pre-approve services that exceeds one (1) day, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.	

Benefit	Description
<p align="center"><b>See Schedule of Coverage and Benefits for Your cost-sharing Amount</b></p> <p align="center">Note: Copayments do not count towards Your Out-of-Pocket (OOP) Maximum; only Deductibles and Coinsurances apply to Your OOP Maximum.</p>	
<b>21. Orthotics</b>	<p>Covered orthotic equipment is the Standard Basic Equipment necessary to continue the Instrumental Activities of Daily Living (IADL). The following items are covered when ordered and provided by a Participating Physician and obtained from a Participating Orthotic Provider:</p> <ul style="list-style-type: none"> <li>• Braces/support including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part are considered Durable Medical Equipment and are a Covered Health Service.</li> <li>• Trusses</li> <li>• Splints</li> <li>• Collars</li> <li>• Foot orthotics are a covered treatment for neuropathy or severe vascular insufficiency due to diabetes, or vascular disease.</li> </ul> <p>Braces that straighten or change the shape of a body part are orthotic devices, and are covered only for Instrumental Activities of Daily Living. Orthotics for sports-related activities are not covered. Dental braces are excluded from coverage. See Section 13, D., G. and H. for mechanical equipment, medical supplies and other related services that are not covered.</p> <p>Any combination of Network and Non-Network Benefits for orthotic devices is limited according to Your Schedule of Coverage and Benefits.</p> <p align="center"><b><u>Prior Authorization Required</u></b></p> <p>Orthotics devices/equipment in excess of \$1,000.00 must be approved in advance by the Plan. Unless We approve orthotic services over \$1,000, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.</p>
<b>22. Osteoporosis Services/Bone Mineral Density (BMD) Testing</b>	<p>Diagnosis, treatment, and appropriate management of osteoporosis for Covered Persons with a condition or medical history for which bone mass measurement is medically indicated.</p> <p align="center"><b><u>Prior Authorization Required</u></b></p> <p>Coverage limitations may apply. Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at <a href="http://www.mercyhealthplans.com">www.mercyhealthplans.com</a> or by calling Our Customer Contact Center at the number listed on Your ID card. Unless We pre-approve BMD testing that requires Prior Authorization, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.</p>
<b>23. Outpatient Diagnostic Services</b>	<p>Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility for laboratory and medical diagnostic services.</p> <ul style="list-style-type: none"> <li>• Laboratory services</li> <li>• X-ray/Imaging services</li> <li>• Other diagnostic tests and therapeutic treatments (including cancer Chemotherapy or intravenous infusion therapy)</li> </ul> <p>[Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.] [Regardless of the place where these services are performed the applicable cost-sharing will apply.]</p> <p>The following services are subject to the outpatient diagnostic cost-sharing, regardless of the place of service:</p> <ul style="list-style-type: none"> <li>• MRA</li> <li>• MRI</li> <li>• CT Scan</li> </ul>

Benefit	Description
	<p align="center"><b>See Schedule of Coverage and Benefits for Your cost-sharing Amount</b></p> <p align="center">Note: Copayments do not count towards Your Out-of-Pocket (OOP) Maximum; only Deductibles and Coinsurances apply to Your OOP Maximum.</p>
	<ul style="list-style-type: none"> <li>• PET Scan</li> <li>• Nuclear Cardiology Imaging studies</li> </ul> <p align="center"><b><u>Prior Authorization Required</u></b></p> <p>Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at <a href="http://www.mercyhealthplans.com">www.mercyhealthplans.com</a> or by calling Our Customer Contact Center at the number listed on Your ID card. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.</p>
<p><b>24. Outpatient Surgery/Hospital Procedures</b></p>	<p>Covered surgical services and other medical care received on an outpatient basis at a Hospital or Alternate Facility. Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for related professional fees are described under <i>Professional Fees for Surgical and Medical Services</i> below and may incur separate Copayment/Coinsurance in addition to the outpatient facility Copayment/Coinsurance. [Regardless of the place where these services are performed, the applicable cost-sharing will apply.]</p> <p><b>Surgical Implants</b>, whether inserted in the inpatient, outpatient, or office setting, including pacemakers, stents, and other implantable devices or treatments. Copayment/Coinsurance is consistent with type of service required. Implants for cosmetic or psychological reasons are excluded, see Section 13, K.</p> <p align="center"><b><u>Prior Authorization Required</u></b></p> <p>Some services require Prior Authorization. A list of services requiring Prior Authorization can be obtained at <a href="http://www.mercyhealthplans.com">www.mercyhealthplans.com</a> or by calling Our Customer Contact Center at the number listed on Your ID card. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses.</p>
<p><b>25. Physician's Office Services</b></p>	<p>Covered Health Services received in a Physician's office including:</p> <ul style="list-style-type: none"> <li>• Treatment of a Sickness or Injury;</li> <li>• Preventive medical care;</li> <li>• Well-baby and well-child care including children's preventive health care services for children from birth through 18 years of age;</li> <li>• Routine physical examinations;</li> <li>• Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment. See <i>Eye Examination</i> earlier in this Section.)</li> <li>• Testing for lead poisoning;</li> <li>• Second opinion rendered by a specialist in that specific diagnosis area, including but not limited to when a patient with a newly diagnosed cancer is referred to such specialist by his or her attending physician. Coverage for this second opinion is subject to the same conditions as any other benefit when the specialist is not a Network Physician.</li> </ul> <p>[For Preventive Health/Wellness care in a Physician's office, see <i>Preventive Health Screenings – Routine Only</i> below.]</p>
<p><b>26. PKU Formula and Medical Foods for Metabolic Disorders</b></p>	<p>Benefits are provided for PKU formula Medical Foods and Low Protein Modified Food Products if the following are met:</p> <ul style="list-style-type: none"> <li>• The Medical Food or Low Protein Modified Food Products are prescribed as medically necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism;</li> <li>• The products are administered under the direction of a physician licensed; and</li> <li>• The cost of the Medical Food or Low Protein Modified Food Products for an individual or a family with a Dependent person or persons exceeds \$2,400 per year per person.</li> </ul>

Benefit	Description
<p align="center"><b>See Schedule of Coverage and Benefits for Your cost-sharing Amount</b></p> <p align="center">Note: Copayments do not count towards Your Out-of-Pocket (OOP) Maximum; only Deductibles and Coinsurances apply to Your OOP Maximum.</p>	
See Section 13, I. for limitations and exclusions related to this Benefit.	
<b>27. Preventive Health Screenings – Routine Only</b>	<p>Preventive Health Screenings in accordance with the American Cancer Society guidelines and additional preventive Benefits provided by Mercy Health Plans. [Preventive Health Screenings listed in this section below are not subject to the Deductible; the Plan pays 100% for the Preventive Health Screenings only when you use Network providers.] Deductible and Coinsurances will apply to services received from a Non-Network Provider.</p> <p>Preventive Health Screenings include one (1) routine test of each of the following every [Calendar] [Rolling] [Plan] Year, unless otherwise indicated:</p> <ul style="list-style-type: none"> <li>• Cholesterol Tests</li> <li>• Colon Screening: <ul style="list-style-type: none"> <li>– Fecal Occult Blood Test</li> <li>– Colonoscopy – one (1) routine screening every ten (10) years starting at age 50</li> <li>– Double-contrast Barium Enema one (1) routine screening every five (5) years starting at age 50</li> <li>– Flexible Sigmoidoscopy one (1) routine screening every five (5) years starting at age 50</li> </ul> </li> <li>• Mammography starting at age 35 and older</li> <li>• Pap Test</li> <li>• Pelvic Exam</li> <li>• Prostate Exam</li> <li>• PSA test starting at age 40</li> <li>• [Preventive care in a Physician's office including: One (1) annual physical exam per [Calendar] [Rolling] [Plan] Year, periodic visits for well-baby and well-child care, hearing and vision screenings.]</li> </ul>
<b>28. Professional Fees for Surgical and Medical Services</b>	<p>Professional fees for surgical procedures and other medical care provided in an outpatient facility. You may incur a separate Copayment/Coinsurance in addition to the outpatient facility charge.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> above.</p>
<b>29. Prosthetics</b>	<ol style="list-style-type: none"> <li>1. The purchase, fitting, necessary adjustment of prosthetic devices which replace or repair all or part of a limb including tissue, or replace all or part of the function of a permanently inoperative or malfunctioning body organ is a covered benefit.</li> <li>2. Supplies, adjustments, and repair or replacement of these devices, necessary to maintain their effective use, is provided when needed due to irreparable damage, normal wear or a change in the patient's condition, and deemed necessary by the Plan. As long as the device remains Medically Necessary, it will be covered even if the device has been in use prior to the user's enrollment; however an item is generally not replaced more than once per [Calendar] [Rolling] [Plan] Year. Covered prosthetic equipment is the Standard Basic Equipment necessary to continue average daily activities. If more than one prosthetic device can meet Your functional needs, Benefits are available only for the most cost-effective prosthetic device. The following devices and related services are not covered as prosthetic equipment:</li> <li>3. All mechanical organs</li> <li>4. Computer assisted devices</li> <li>5. Dental and TMJ appliances</li> <li>6. Devices employing robotics</li> </ol>

Benefit	Description
	<p align="center"><b>See Schedule of Coverage and Benefits for Your cost-sharing Amount</b></p> <p align="center">Note: Copayments do not count towards Your Out-of-Pocket (OOP) Maximum; only Deductibles and Coinsurances apply to Your OOP Maximum.</p> <ol style="list-style-type: none"> <li>7. Electrical continence aids, anal or urethral</li> <li>8. Investigational or obsolete devices and supplies</li> <li>9. Remote control devices</li> <li>10. See Section 13, K., Q., B and C., for more details on related exclusions.</li> <li>11. Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998 is also covered. Breast prosthesis may follow a mastectomy at any time. Coverage includes a post-mastectomy brassiere. Please note that any limitation for prosthetics does not apply to breast prostheses.</li> <li>12. Note: The Plan is not responsible for any DME/Orthotics/Prosthetics loss or damage that is that is the result of action of a third party (i.e., loss of luggage containing DME equipment or orthotic/prosthetic devices by an airliner).</li> <li>13. [Any combination of Network and Non-Network Benefits for DME, Orthotics and Prosthetics [(combined Benefit)] is limited according to Your Schedule of Coverage and Benefits.]</li> </ol> <p align="center"><b><u>Prior Authorization Required</u></b></p> <p>We must pre-approve any single item of prosthetics that costs more than \$1,000 (either purchase price or cumulative rental of a single item). Unless We pre-approve services over \$1,000, You will be responsible for paying 100% of the charges and no Benefits will be paid.</p>
<p><b>30. Reconstructive Procedures</b></p>	<p>Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.</p> <p>Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure. See Section 13, K. for related limitations and exclusions.</p> <p>Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy related to breast disease, and reconstruction of the non-affected breast to achieve symmetry. Reconstructive surgery for breast reconstruction and the receipt of related prosthetic devices may follow a mastectomy at any time. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact Us at the telephone number on Your ID card for more information about Benefits for mastectomy-related services.</p> <p align="center"><b><u>Prior Authorization Required</u></b></p> <p>You must notify Us before receiving services. When You notify Us, We can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage. Unless We pre-approve a Covered reconstructive Service, Network and Non-Network Benefits for reconstructive procedures will be reduced by 100% of Eligible Expenses.</p>
<p><b>31. Rehabilitation Services</b></p>	<p><b><i>Outpatient Rehabilitation Therapy</i></b></p> <p>Short-term outpatient rehabilitation services for:</p>

Benefit	Description
<p align="center"><b>See Schedule of Coverage and Benefits for Your cost-sharing Amount</b></p> <p align="center">Note: Copayments do not count towards Your Out-of-Pocket (OOP) Maximum; only Deductibles and Coinsurances apply to Your OOP Maximum.</p>	
<p><b>32. Skilled Nursing Facility (SNF)</b></p>	<ul style="list-style-type: none"> <li>• Physical Therapy</li> <li>• Occupational Therapy</li> <li>• Speech Therapy</li> <li>• Pulmonary Rehabilitation therapy</li> <li>• Cardiac Rehabilitation therapy</li> </ul> <p>Also includes covered Health Services received on an outpatient basis at a Hospital or Alternate Facility for treatment for loss or impairment of speech or hearing.</p> <p>“Short-term” means rehabilitation services that are expected to result in significant physical improvement in Your condition within two (2) months of the start of treatment.</p> <p>Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Home rehabilitation services are limited to the Homebound patient and considered separately under the home health Benefit.</p> <p>Please note that We will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly. Exclusions are described in Section 13, P. Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits.</p> <p><b><i>Inpatient Rehabilitation Services</i></b></p> <p>Medically Necessary services for an Inpatient Stay in an Inpatient Rehabilitation Facility. Benefits are available for:</p> <ul style="list-style-type: none"> <li>• Services and supplies received during the Inpatient Stay</li> <li>• Room and board in a Semi-Private Room</li> </ul> <p>Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.</p> <p align="center"><b><u>Prior Authorization Required</u></b></p> <p>We must pre-approve services for an elective or non-elective inpatient rehabilitation admission. Unless We pre-approve inpatient rehabilitation services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses. For Emergency Admission, You must notify Us within two (2) business days or as soon as reasonably possible.</p> <p>Medically Necessary services for an Inpatient Stay in a Skilled Nursing Facility. Benefits are available for:</p> <ul style="list-style-type: none"> <li>• Services and supplies received during the Inpatient Stay</li> <li>• Room and board in a Semi-Private Room (a room with two or more beds)</li> </ul> <p>Any combination of Network and Non-Network Benefits is limited according to Your Schedule of Coverage and Benefits. Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.</p> <p align="center"><b><u>Prior Authorization Required</u></b></p> <p>We must pre-approve services for an elective or non-elective SNF admission. Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 50% of Eligible Expenses. For emergency admission, You must notify Us within two (2) business days or as soon as reasonably possible.</p>
<p><b>33. Spinal Manipulation</b></p>	<p>Benefits for Spinal Manipulation when provided by a licensed Spinal Manipulation provider in the provider’s office. Benefits for Spinal Manipulation are limited to one (1) visit and treatment per day. Any combination of Network and Non-Network Benefits for Spinal Manipulation is</p>

Benefit	Description
<p align="center"><b>See Schedule of Coverage and Benefits for Your cost-sharing Amount</b></p> <p align="center">Note: Copayments do not count towards Your Out-of-Pocket (OOP) Maximum; only Deductibles and Coinsurances apply to Your OOP Maximum.</p>	
	<p>limited according to Your Schedule of Coverage and Benefits.</p>
<b>34. Tobacco Cessation Education Program</b>	<p>[Education Benefits are available for up to one (1) tobacco cessation group support program per year. Providers generally offer at least five (5) American Lung Association certified sessions per program. One Copayment/Coinsurance applies to each program. Tobacco cessation products are available only through a prescription drug Rider.]</p>
<b>35. Transplant Services</b>	<p>Covered Health Services for the following organ and tissue transplants when ordered by a Physician. For Network Benefits, transplant services must be received at an approved facility in the designated transplant Network. Benefits are available for the transplants listed below when the transplant is Medically Necessary and is not an Experimental, Investigational or Unproven Service:</p> <ul style="list-style-type: none"> <li>• Bone marrow transplants (either from You or from a compatible donor) and peripheral stem cell transplants, with or without high dose Chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. Benefits include the treatment of breast cancer by dose-intensive Chemotherapy bone marrow transplants or stem cell transplants, when performed pursuant to nationally accepted peer review protocols.</li> <li>• Heart transplants</li> <li>• Heart/lung transplants</li> <li>• Lung transplants</li> <li>• Kidney transplants</li> <li>• Kidney/Pancreas transplants</li> <li>• Kidney/Liver</li> <li>• Liver transplants</li> <li>• Liver/small bowel transplants</li> <li>• Pancreas transplants</li> <li>• Small bowel transplants</li> </ul> <p>Benefits are also available for cornea transplants that are provided by a Physician at a Hospital. We do not require that cornea transplants be performed at a Designated Facility in order for You to receive Network or Non-Network Benefits. Corneal transplant does not require Prior Authorization.</p> <p>We have specific guidelines regarding Benefits for transplant services and there are related limitations in Section 13, Q. Contact Us at the telephone number on Your ID card for information about these guidelines.</p> <p><u>Note:</u> You have the option to receive Non-Network care; however, Non-Network transplant Benefits will be paid at the Usual and Customary global fee, which could result in much greater out-of-pocket costs.</p>
<p align="center"><b><u>Prior Authorization Required</u></b></p>	
<p>You must notify Us as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). Unless We pre-approve these services (and before a pre-transplantation evaluation is performed at a transplant center), Network and Non-Network Benefits for transplant will be reduced by 100% of Eligible Expenses.</p>	
<b>36. Urgent Care Center Services</b>	<p>Covered Health Services received at an Urgent Care Center. If radiology and other diagnostics services are provided and billed separately from the Urgent Care Center, additional Copayments/Coinsurances may apply.</p> <p>[When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under <i>Physician's Office Services</i> above.] [When Urgent Care services are provided in a Physician's office, applicable Copayment/Coinsurance will be charged, regardless</p>

Benefit	Description
	<p data-bbox="631 149 1352 180"><b>See Schedule of Coverage and Benefits for Your cost-sharing Amount</b></p> <p data-bbox="498 189 1484 249">Note: Copayments do not count towards Your Out-of-Pocket (OOP) Maximum; only Deductibles and Coinsurances apply to Your OOP Maximum.</p> <p data-bbox="469 258 987 289">of the place where these services are performed.]</p>

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## Section 13: Exclusions – Things We Don’t Cover

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This Section contains information about Medical services that are not covered. We call these Exclusions. It is important for You to know what services and supplies are not covered under this Policy.

### **We do not pay Benefits for exclusions or any related complications.**

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if any of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for Your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in Section 12 (Covered Benefits) or through a Rider to this Policy.

Category	Description														
<b>A. Alternative Treatments</b>	We do not cover alternative treatments, including but not limited to: <ol style="list-style-type: none"><li>1. Acupressure [and Acupuncture.]</li><li>2. Aromatherapy.</li><li>3. Hypnotism.</li><li>4. Massage Therapy.</li><li>5. Rolfing.</li><li>6. Herbal remedies.</li><li>7. Ayurvedic therapies.</li><li>8. Reflexology.</li><li>9. Biofeedback and neurofeedback therapy.</li><li>10. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.</li></ol>														
<b>B. Comfort or Convenience</b>	<ol style="list-style-type: none"><li>1. Television.</li><li>2. Telephone.</li><li>3. Beauty/Barber service.</li><li>4. Guest service.</li><li>5. Automated travel devices (motor scooters).</li><li>6. Supplies, equipment and similar incidental services and supplies for personal comfort or convenience. Examples include:<table><tr><td>- Air conditioners</td><td>- Air purifiers and filters</td></tr><tr><td>- Batteries and battery chargers</td><td>- Dehumidifiers and Humidifiers</td></tr><tr><td>- Electrostatic machines</td><td>- Lights/lighting</td></tr><tr><td>- Portable room heaters, grab bars, etc.</td><td>- Vaporizers</td></tr><tr><td>- Tanning booths,</td><td>- Bath chairs</td></tr><tr><td>- Breast pumps unless newborn is in NICU</td><td>- Exercise equipment</td></tr><tr><td>- Raised or regular toilet seats</td><td>- Whirlpools, saunas, and hot tubs</td></tr></table></li><li>7. Devices and computers to assist in communication and speech. Augmentative communication devices, including but not limited to computer assisted speech devices, speech teaching machines, telephones, TDD equipment, Braille teaching texts, computers, and telephone alert systems. Exceptions include basic, Non-digital voice systems, such as the Electro-Larynx, after post-radical neck or other invasive surgery that interferes with laryngeal function.</li><li>8. Personal hygiene items and hygienic items, including but not limited to shower chairs, commodes (unless the individual is confined to room or bed), incontinence pads, bed baths, etc.</li><li>9. Devices that are primarily non-medical in nature or used primarily for comfort, including but not limited to:</li></ol>	- Air conditioners	- Air purifiers and filters	- Batteries and battery chargers	- Dehumidifiers and Humidifiers	- Electrostatic machines	- Lights/lighting	- Portable room heaters, grab bars, etc.	- Vaporizers	- Tanning booths,	- Bath chairs	- Breast pumps unless newborn is in NICU	- Exercise equipment	- Raised or regular toilet seats	- Whirlpools, saunas, and hot tubs
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- Breast pumps unless newborn is in NICU	- Exercise equipment														
- Raised or regular toilet seats	- Whirlpools, saunas, and hot tubs														

Category	Description
	<ul style="list-style-type: none"> <li>- Bed boards</li> <li>- Elevators</li> <li>- Foam pads</li> <li>- Heating pads</li> <li>- Beds other than standard single hospital beds</li> <li>- Carafes</li> <li>- Emesis basins</li> <li>- Maternity belts</li> <li>- Bathtub seats</li> <li>- Standing tables</li> <li>- Overbed tables</li> </ul>
	10. Chair lifts, bathtub lifts, bed lifter, and other similar devices.
	11. Exercise equipment including but not limited to parallel bars, weights, bicycles, rowing machines, and treadmills.
<b>C. Dental</b>	<ol style="list-style-type: none"> <li>1. Dental care except as described in Section 12 (Covered Benefits) under the heading, "Dental Services Accident Only" and "Dental – Anesthesia and Facility Charges".</li> <li>2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, whether the services are considered to be medical or dental in nature. Examples include all of the following: <ul style="list-style-type: none"> <li>– Extraction, restoration and replacement of teeth;</li> <li>– Medical or surgical treatments of dental conditions;</li> <li>– Services to improve dental clinical outcomes;</li> <li>– Services for overbite or underbite;</li> <li>– Services related to surgery for cutting through the lower or upper jaw bone;</li> <li>– Maxillary and mandibular osteotomies</li> </ul> </li> <li>3. Dental implants and associated oral surgery and supplies, even if associated with Accidental Dental Services. This includes but is not limited to any enabling procedures for implants, as well as placement, maintenance, restoration, and removal of dental implants. Any prosthetic superstructure fabricated upon a dental implant is also excluded.</li> <li>4. Dental braces and occlusal splints, even if associated with Accidental Dental Services.</li> <li>5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are limited dental x-rays and for any of the following: <ul style="list-style-type: none"> <li>• Transplant preparation;</li> <li>• Initiation of immunosuppressives;</li> <li>• The direct treatment of acute traumatic Injury;</li> <li>• The direct treatment of cancer (i.e., injury to teeth as a direct effect of cancer treatment);</li> <li>• Cleft palate;</li> <li>• Covered Persons with conditions outlined in Section 12(Covered Benefits) under Dental – Anesthesia and Facility Charges;</li> </ul> </li> <li>6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.</li> <li>7. Orthodontic services.</li> <li>8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.</li> <li>9. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic injury or cancer.</li> <li>10. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint syndrome, except as a treatment of obstructive sleep apnea.</li> </ol>
<b>D. Drugs</b>	<ol style="list-style-type: none"> <li>1. Prescription drug products for outpatient use (including self-injectables) that are filled by a prescription order or refill.</li> <li>2. Non-injectable medications given in a Physician's office except as required in an Emergency.</li> <li>3. Over the counter drugs and treatments.</li> <li>4. Charges for supplies for use beyond the first twenty-four (24) hours following discharge from the Hospital as an Inpatient or following the provision of Emergency</li> </ol>

Category	Description
	Care, including any prescription drugs intended primarily for home use.
<b>E. Experimental, Investigational or Unproven Services</b>	Experimental, Investigational or Unproven Services are excluded. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
<b>F. Foot Care</b>	<ol style="list-style-type: none"> <li>1. Routine foot care (including the cutting or removal of corns and calluses).</li> <li>2. Nail trimming, cutting, or debriding, unless the charges are for the removal of a nail or root in connection with the treatment of a metabolic or peripheral-vascular disease or infection.</li> <li>3. Hygienic and preventive maintenance foot care. Examples include the following: <ul style="list-style-type: none"> <li>– Cleaning and soaking the feet;</li> <li>– Applying skin creams in order to maintain skin tone;</li> <li>– Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.</li> </ul> </li> <li>4. Treatment of flat feet, painful feet, fallen arches, metatarsalgia, plantar fasciitis, neuromas, tendonitis, bursitis, varus or valgus deformities, and other conditions of the feet unless otherwise noted in this document.</li> <li>5. Treatment of subluxation of the foot.</li> <li>6. Shoe orthotics, orthopedic shoes and other supportive appliances for feet, except as otherwise noted in this document.</li> </ol>
<b>G. Hearing Aid</b>	<ol style="list-style-type: none"> <li>1. Charges for hearing aid batteries, listening devices and/or repairs, and any additional charges for functionality enhancements and/or components.</li> <li>2. Hearing aids when the device cannot assist the hearing loss.</li> <li>3. BAHA or osseointegrated hearing aids.</li> </ol>
<b>H. Medical Supplies and Appliances</b>	<ol style="list-style-type: none"> <li>1. Devices used specifically as safety items or to affect performance in sports-related activities.</li> <li>2. Prescribed or non-prescribed medical supplies and disposable supplies, except as provided elsewhere in this Certificate. Examples include but are not limited to: <ul style="list-style-type: none"> <li>• Elastic stockings</li> <li>• Gauze and dressings</li> <li>• Fabric supports</li> <li>• Incontinent pads, including diapers</li> <li>• Ace bandages</li> <li>• Disposable sheets and bags</li> <li>• Surgical face masks</li> <li>• Pressure leotards</li> </ul> </li> <li>3. Orthotic and prosthetic appliances for sports-related activities.</li> <li>4. Tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 12 (Schedule of Coverage and Benefits).</li> <li>5. Devices and equipment that are not normally appropriate outside of a hospital (or other provider) setting, including but not limited to:</li> <li>6. Home monitoring devices and supplies, except Medically Necessary cardiac monitoring devices (such as holter monitors and event recorders)</li> <li>7. Home prenatal monitoring and associated nursing support</li> <li>8. The following are excluded under the medical Benefit, only if MHP pharmacy Benefit coverage is available::</li> <li>9. Insulin syringes with needles</li> <li>10. Lancets and lancet devices</li> <li>11. Glucometers, test strips and related supplies.</li> <li>12. Lift Seats.</li> </ol>
<b>I. Mental Health/Substance Abuse</b>	<ol style="list-style-type: none"> <li>1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.</li> <li>2. Services utilizing methadone treatment as maintenance, L.A.A.M (1-Alpha-Acetyl-</li> </ol>

Category	Description
	<p>Methadone), Cyclozocine, or their equivalents.</p> <ol style="list-style-type: none"> <li>3. Psychosurgery.</li> <li>4. Vagus nerve stimulation (VNS) for depression.</li> <li>5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements unless medically necessary and authorized by the Mental Health/Substance Abuse Designee. Medically Necessary care may include any of the following: <ol style="list-style-type: none"> <li>a. Not consistent with prevailing national standards of clinical practice for the treatment of such conditions including but not limited to Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short term evaluation, diagnosis, treatment or crisis intervention.</li> <li>b. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.</li> <li>c. Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.</li> <li>d. Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.</li> </ol> </li> <li>6. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Designee, are any of the following: <ol style="list-style-type: none"> <li>a. Not consistent with prevailing national standards of clinical practice for the treatment of such conditions including but not limited to Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short term evaluation, diagnosis, treatment or crisis intervention.</li> <li>b. Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome.</li> <li>c. Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective.</li> <li>d. Not consistent with the Mental Health/Substance Abuse Designee's level of care guidelines or best practices as modified from time to time.</li> </ol> </li> <li>7. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis. Intervention.</li> <li>8. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis.</li> <li>9. Treatment or services, except for the initial diagnosis, for a primary diagnosis of Mental Retardation, Learning, Motor Skills, and Communication Disorders, Pervasive Developmental Disorder, Conduct Disorder, Dementia, Sexual, Paraphilia, and Gender Identity Disorders, and Personality Disorders, as well as other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Designee.</li> <li>10. Residential treatment services.</li> </ol> <p>The Mental Health/Substance Abuse Designee may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.</p>
<b>J. Nutrition</b>	<ol style="list-style-type: none"> <li>1. Megavitamin and nutrition based therapy (for any purpose).</li> <li>2. Vitamins</li> <li>3. Nutritional counseling and other hospital-based educational programs for either individuals or groups, except for treatment of Diabetes or certain illnesses or conditions.</li> <li>4. Medical foods and other nutritional and electrolyte supplements taken orally or enterally regardless of the disease state, including infant formula and donor breast milk. This exclusion does not apply to the treatment of Phenylketonuria or any</li> </ol>

Category	Description
	<p>inherited disease of amino or organic acids, or nutritional supplements ordered by a Physician in connection with home care, which requires the Member to have a feeding tube as a sole source of nutrition.</p>
<b>K. Personal</b>	<ol style="list-style-type: none"> <li>Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when: <ol style="list-style-type: none"> <li>Required solely for purposes of career, education, sports or camp, travel, recreation, employment, insurance, marriage or adoption.</li> <li>Related to judicial or administrative proceedings or orders.</li> <li>Conducted for purposes of medical research.</li> <li>Required to obtain or maintain a license of any type.</li> </ol> </li> <li>Custodial Care. See Section 14 (Definitions of Terms).</li> <li>Domiciliary care or any nursing care on full-time basis in Your home.</li> <li>Private Duty Nursing. See Section 14 (Definitions of Terms).</li> <li>Respite care.</li> <li>Rest cures.</li> <li>Medical and surgical treatment of excessive sweating (hyperhidrosis).</li> <li>Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.</li> <li>Oral appliances for snoring.</li> <li>Care for an Injury or Illness resulting from participation in, or in consequence of having participated in an illegal occupation or the commission of an assault or felony, except for injuries that result from an act of domestic violence.</li> <li>Work place evaluations and work hardening treatment.</li> <li>Educational programs and health education services</li> <li>Non-medical services including, but not limited to: home &amp; work-site environmental evaluations, educational and behavioral evaluations performed at school; vocational rehabilitation and training; modifications to a house, apartment or other domicile for purposes of accommodating persons with medical conditions or disabilities; housekeeping services provided on an inpatient, out-patient or in-home basis; testing to determine parentage; speech therapy for foreign accent reduction; pastoral or bereavement services; procedures or treatment for ceremonial rituals; fetal cord blood harvesting and storage, and other services performed outside of the medical environment of unproven medical benefit.</li> </ol>
<b>L. Physical Appearance</b>	<ol style="list-style-type: none"> <li>Cosmetic Procedures. See the definition in Section 14 (Definitions of Terms). Examples include: <ul style="list-style-type: none"> <li>Pharmacological regimens, nutritional procedures or treatments;</li> <li>Scar, keloid or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);</li> <li>Skin abrasion procedures performed as a treatment for acne;</li> <li>Liposuction;</li> <li>Hair transplant for baldness;</li> <li>Correction of asymmetric breasts or abnormal nipple-areolar complexes and protruding ears;</li> <li>All other cosmetic services <b>except</b> if medically necessary to: <ol style="list-style-type: none"> <li>Repair a functional disorder caused by a disease or an accidental injury suffered while insured by the Plan;</li> <li>Restore or improve function for a structurally abnormal Congenital or developmental defect or anomaly in a Member under age nineteen (19). Anomaly is defined as a marked deviation beyond the range of normal human variation; or</li> <li>Reconstructive breast surgery performed post-mastectomy;</li> </ol> </li> </ul> </li> <li>Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.</li> <li>Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.</li> <li>Weight loss programs whether or not they are under medical supervision. Weight loss</li> </ol>

Category	Description
	<p>programs for medical reasons are also excluded.</p> <ol style="list-style-type: none"> <li>Wigs, regardless of the reason for the hair loss, except as otherwise provided by law.</li> <li>Treatment of benign gynecomastia (abnormal breast enlargement in males).</li> <li>Surgical and Non-surgical treatment of obesity, including morbid obesity. Treatment includes but is not limited to, stomach stapling, jaw wiring, gastric banding, gastric balloon or bypass surgery, dietary/nutritional supplements, behavioral/community support programs, exercise programs, and medical testing, medications, and office visits associated with any weight loss program.</li> <li>Growth hormone except as determined Medically Necessary by the Plan to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat idiopathic short stature (ISS) is expressly excluded.</li> <li>Sex transformation operations.</li> <li>Breast Reduction Surgery (Reduction Mammoplasty).</li> <li>Hair transplant for baldness.</li> </ol>
<b>M. Preexisting Conditions</b>	<p>Benefits for the treatment of a Preexisting Condition are excluded until the date You have been covered under this Policy for a period of twelve (12) months, except this waiting period will not apply to:</p> <ul style="list-style-type: none"> <li>A child who is placed in a Member's physical custody for purposes of adoption if the petition for adoption is filed within sixty (60) days of placement of such child; or</li> <li>A newborn if an application for coverage is filed within ninety (90) days of the birth of the child.</li> <li>A person who has had creditable coverage for twelve (12) months without a break of sixty-three (63) days or more.</li> </ul>
<b>N. Providers</b>	<ol style="list-style-type: none"> <li>Services performed by a provider who is a family member by birth or marriage, including Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.</li> <li>Services performed by a provider with Your same legal residence.</li> <li>Services provided at a freestanding or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital based diagnostic facility. Services ordered by a Physician or other provider who <i>is</i> an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider: <ol style="list-style-type: none"> <li>Has not been actively involved in Your medical care prior to ordering the service, or</li> <li>Is not actively involved in Your medical care after the service is received.</li> </ol> <p>This exclusion does not apply to mammography testing.</p> </li> <li>Charges Incurred for broken appointments with a Participating Physician.</li> </ol>
<b>O. Reproduction</b>	<ol style="list-style-type: none"> <li>Health services and associated expenses for Infertility treatments including, but not limited to, medical care or prescription drugs used to stimulate ovulation, or assisted reproductive technology (ART). ART includes any combination of chemical and/or mechanical means of obtaining a mature male or female reproductive cell and placing it into a medium (whether internal or external to the human body) to enhance the chance reproduction will occur. Examples of ART include, but are not limited to, artificial insemination, in vitro fertilization, gametic intra fallopian transfer, zygote intra fallopian transfer, pronuclear state tubal transfer and surrogate Pregnancy.</li> <li>Surrogate parenting.</li> <li>Voluntary sterilization or the reversal of voluntary sterilization.</li> <li>Health services and associated expenses for elective abortion. Elective abortion means an abortion for any reason other than a spontaneous abortion or loss of the fetus as a result of the only treatment available to save the life of the mother.</li> <li>Contraceptive supplies and services.</li> <li>Fetal reduction surgery.</li> <li>Health services associated with the use of non-surgical or drug induced Pregnancy termination.</li> </ol>

Category	Description
	<ol style="list-style-type: none"> <li>Services (including pharmaceuticals) provided in connection with treatment or surgery to change gender or restore sexual function, unless otherwise covered in this Policy.</li> <li>Maternity Services - Complications of Pregnancy, however, are covered.</li> </ol>
<b>P. Services Provided under Another Plan</b>	<ol style="list-style-type: none"> <li>Health service for which other coverage is required by Federal, state or local law to be purchased or provided through other arrangements.</li> <li>Health services for treatment of Injury, Sickness or Mental Illness arising out of or in the course of, any employment, whether or not covered by Workers' Compensation or similar law. If coverage under Workers' Compensation or similar legislation is optional for You because You could elect it, or could have it elected for You, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under Workers' Compensation or similar legislation if that coverage had been elected.</li> <li>Health services for treatment of military service-related disabilities, when You are legally entitled to other coverage and facilities are reasonably available to You.</li> <li>Health services while on active military duty. Upon notifying Mercy Health Plans of entry into military service, any pro-rata unearned premiums shall be refunded.</li> <li>Injury or Illness incurred while incarcerated in any local, municipal, state or Federal facility.</li> </ol>
<b>Q. Therapies/Psychological Testing</b>	<ol style="list-style-type: none"> <li><u>Speech, physical, occupational, and other rehabilitative services solely for speech/language delays (unless otherwise covered under this Agreement or by law). Speech, physical, occupational, and other rehabilitative services are not covered except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.</u></li> <li><u>Psychological testing for services that are considered primarily educational or training in nature or related to improving academic or work performance.</u></li> <li><u>Neuropsychological Testing to assist in planning educational, training, and vocational programs, for the purpose of disability determinations, and/or for forensic determinations.</u></li> <li><u>Educational Services, unless Medically Necessary and clinically appropriate for the treatment of learning disorders and acquired cognitive deficits.</u></li> <li><u>Water exercise and other exercises not under the supervision of a physical therapist.</u></li> <li><u>Services or supplies that cannot reasonably be expected to lessen a Member's ability to live outside an institution.</u></li> <li><u>Recreational, equine, psychodrama, chelation (removal of excessive heavy metals ions from the body) sleep and activity therapy, e.g. music, dance, art or play therapy.</u></li> </ol>
<b>R. Transplants</b>	<ol style="list-style-type: none"> <li>Health services for organ and tissue transplants, except those described in Section 12 (Covered Benefits).</li> <li>Health services connected with the removal of an organ or tissue from You for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under this Policy).</li> <li>Health services for transplants involving mechanical or animal organs.</li> <li>Any multiple organ transplant not listed as a Covered Health Service under the heading <i>Transplantation Health Services</i> in Section 12 (Covered Benefits).</li> </ol>
<b>S. Travel</b>	<ol style="list-style-type: none"> <li>Health services provided in a foreign country, unless required as Emergency Health Services.</li> <li>Travel or transportation expenses, even though prescribed by a Physician, except for medically necessary ambulance services. Some travel expenses related to covered transplantation services may be reimbursed at Our direction.</li> <li>Air Ambulance Services outside the continental United States for any reason.</li> </ol>
<b>T. Vision and Hearing</b>	<ol style="list-style-type: none"> <li>Purchase cost of eye glasses, contact lenses (except for eyeglasses or contact lenses prescribed following cataract surgery, up to a maximum of a \$300.00 dollar benefit per lifetime), or hearing aids.</li> <li>Fitting charge for hearing aids, eye glasses or contact lenses.</li> </ol>

Category	Description
	<ol style="list-style-type: none"> <li>3. Eye exercise therapy (orthoptics or pleoptic training).</li> <li>4. Surgery that is intended to allow You to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.</li> </ol>
<b>U. General/Administrative</b>	<ol style="list-style-type: none"> <li>1. Health services and supplies that are not included in Section 12 (Covered Benefits), or that do not meet the definition of a Covered Health Service - see the definition in Section 14 (Definitions of Terms).</li> <li>2. Health services received as a result of any catastrophic act or incident of war, whether declared or undeclared or caused during service in the armed forces of any country.</li> <li>3. Health services received after the date Your coverage under this Policy ends, including health services for medical conditions arising before the date Your coverage under this Policy ends.</li> <li>4. Health services for which You have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.</li> <li>5. Charges in excess of the Usual and Customary Rate (UCR), or in excess of any specified limitation.</li> <li>6. Complications of Health Care Services that are not Covered Health Services, except for Complications of Pregnancy.</li> <li>7. Charges made for completion of forms and/or filing of claims in connection with the Benefits provided under this Plan.</li> <li>8. Autopsies (post-mortem exams)</li> <li>9. Charges associated with a Never Event.</li> </ol>

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## Section 14: Definitions of Terms

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<b><i>Adverse Determination</i></b>	A decision by Mercy Health Plans that an admission, availability of care or continued stay has been reviewed and, based upon the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is considered experimental or investigational leading to a decision that coverage for the requested service is denied, reduced or terminated.
<b><i>Allowable Expense</i></b>	The necessary, reasonable and customary item of expense for health care when the item is covered at least in part under any of the plans involved in coordination of Benefits.
<b><i>Alternate Facility</i></b>	<p>A health care facility that is not a Hospital or a facility that is attached to a Hospital and that is designated by the Hospital as an Alternate Facility. This facility provides one or more of the following services on an outpatient basis, as permitted by law:</p> <ul style="list-style-type: none"><li>• Pre-scheduled surgical services</li><li>• Emergency Room Services</li><li>• Pre-scheduled rehabilitative, laboratory or diagnostic services</li></ul>
<b><i>Amendment</i></b>	Any attached written description of additional or alternative provisions to this Policy. Amendments are effective only when signed by Us. Amendments are subject to all conditions, limitations and exclusions of this Policy, except for those that are specifically amended.
<b><i>Annual Deductible/Deductible</i></b>	If applicable, the amount You must pay for Covered Health Services in a Calendar Year before We will begin paying for Benefits in that Calendar Year. Deductible amounts are separate from and not reduced by Copayments. Deductible and Copayments are in addition to any Coinsurance You pay. The Annual Deductible is included with any Coinsurance You pay to calculate Your total Out-of-Pocket Maximum.
<b><i>Benefits</i></b>	Your right to payment for Covered Health Services that are available under this Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including this document and any attached Riders and Amendments.
<b><i>Calendar Year</i></b>	January 1 through December 31 of the same year.
<b><i>Cardiac Rehabilitation</i></b>	A comprehensive program to rehabilitate the heart.
<b><i>Case Management</i></b>	<p>A coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health Conditions. Case Management may include:</p> <ol style="list-style-type: none"><li>1. Assessment of the Your individual benefit needs;</li><li>2. Formulation and modification of a comprehensive benefit plan of action;</li><li>3. Coordination of Benefits;</li><li>4. Evaluation of the effectiveness of the plan of action; and</li><li>5. Negotiation of extra-contractual services, if necessary.</li></ol>
<b><i>Chemotherapy</i></b>	Treatment of disease by FDA-approved anti-neoplastic agents.
<b><i>Coinsurance</i></b>	Coinsurance is the percentage of Our allowance that You must pay for Your care. You may also be responsible for other costs for Your care such as a Deductible. See Section 6 (Your Cost for Covered Services).
<b><i>Complaint</i></b>	Any communication primarily expressing a Grievance to the Plan by, or on behalf of the Member, or by the health care provider. For purposes of this definition, communication is a written notice relating to the Plan's determinations, procedures, and administration and written or oral notice filed under the expedited Health Care Services appeal process or under the Utilization Review process.

***Complications of Pregnancy***

Means:

- a) Conditions requiring hospital confinement (when pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are affected by pregnancy, including but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest period during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
- b) Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

***Congenital***

Existing or dating from birth; acquired through development while in the uterus.

***Congenital Anomaly***

A physical developmental defect that is present at birth, and is identified within the first twelve (12) months of birth.

***Continuous Creditable Coverage***

Health care coverage under any of the types of plans listed below, during which there was a break in coverage of no more than sixty-three (63) consecutive days, and provided there were eighteen (18) continuous months of eligible coverage:

- A group or individual health plan;
- Self-funded health plan coverage permitted by ERISA;
- Medicare;
- Medicaid;
- Medical and dental care for Members and certain former Members of the uniformed services, and for their dependents;
- A medical care program of the Indian Health Services Program or a tribal organization;
- A state health benefit's risk pool;
- The Federal Employees Health Benefits Program;
- Any public health benefit program provided by a state, county, or other public subdivision of a state;
- A health benefit plan under the Peace Corps Act.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

***Copayment***

A Copayment is a fixed amount of money You pay when You receive Covered Services. See Section 5 (Your Cost for Covered Services).

***Cosmetic Procedures***

Procedures or services that change or improve appearance without significantly improving physiological function, as determined by Us.

***Covered Health Service(s)/Covered Services***

A Covered Health Service is a Health Care Service or supply described in Section 12 (Covered Benefits) as a Covered Health Service. A Covered Health Service is a Health Care Service or supply which is not excluded under Section 13 (Exclusions) and meets the following conditions:

- 1) Prescribed by a Physician for the therapeutic treatment of Injury, Illness or Complications of Pregnancy;
- 2) Deemed Medically Necessary and appropriate in type, level, setting, and length of service; and if required by the Plan, is authorized on a prospective and timely basis by the Plan.
- 3) Rendered in accordance with generally accepted medical practice and professionally recognized standards;
- 4) Provided on or after the Effective Date and before Your coverage terminates in

accordance with Section 3 (When Coverage Ends) and at a time when You met all applicable requirements for eligibility set forth in Section 2 (When Coverage Begins).

- 5) Not considered to be Experimental, Investigational, or which are performed for research purposes;
- 6) Services that are specifically included and not excluded or limited, or not specifically excluded by the Plan.

***Covered Person***

Either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under this Policy. References to "You" and "Your" throughout this Policy are references to a Covered Person.

***Custodial Care***

Services that:

- Are Non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); *or*
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

***Dependent***

The Subscriber's legal Spouse or an unmarried Dependent child of the Subscriber. The term child includes any of the following:

- A natural child;
- A stepchild;
- A legally adopted child;
- A child placed for adoption;
- A child for whom permanent legal guardianship has been awarded to the Subscriber or the Subscriber's Spouse.

To be eligible for coverage under this Policy, a Dependent's domicile and his/her primary residence must be in Arkansas. The definition of Dependent is subject to the conditions and limitations.

- A Dependent includes any unmarried Dependent child under 19 years of age;
- A Dependent includes an unmarried Dependent child who is 19 years of age or older to 23 years of age only if You furnish evidence upon Our request, satisfactory to Us, of all the following conditions:
  - The child must not be regularly employed on a full-time basis;.
  - The child must be a Full-Time Student;
  - The child must be primarily Dependent upon the Subscriber for support and maintenance.

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. The Enrolling Individual is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A Dependent does not include anyone who is enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

***Designated Facility***

A Hospital that We name as a Designated Facility. A Designated Facility has entered into an agreement with Us, or with an organization contracting on Our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within Our geographic area.

***Durable Medical Equipment***

Medical equipment that is all of the following:

- Can withstand repeated use;
- Is not disposable;

- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms;
- Is appropriate for use in the home.

***Educational Service***

A service provided as a means of training Members through formal instruction and supervised practice. Educational Services include those services designed to assist Members who do not currently meet maturation expectations in making progress towards those goals.

***Effective Date***

The date coverage begins for You and any applicable Dependent(s) under this Policy, as determined by Us

***Eligible Expenses***

The amount We will pay for Covered Health Services, incurred while this Policy is in effect, are determined as stated below:

Eligible Expenses are determined solely in accordance with Our reimbursement policy guidelines. We develop Our reimbursement policy guidelines, in Our discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association;
- As reported by generally recognized professionals or publications;
- As used for Medicare;
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that We accept.

***Eligible Person***

The Enrolling Individual specified in both the application and the Policy. An Eligible Person's domicile and primary residence must be located within Arkansas.

***Emergency***

The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but will not be limited to any of the following:

- Placing the person's health in significant jeopardy;
- Serious impairment to a bodily function;
- Serious dysfunction of any bodily organ or part;
- Inadequately controlled pain;
- With respect to a pregnant woman who is having contractions, either of the following:
  - Inadequate time to affect a safe transfer of a pregnant woman to another hospital before delivery;
  - The transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

***Emergency Care/Emergency Room Services***

Health Care Services and supplies necessary for the treatment of an Emergency.

***Enrolled Dependent***

A Dependent who is properly enrolled under this Policy.

***Enrolling Individual***

The individual to whom the Policy is issued.

***Experimental or Investigational Services***

Medical, surgical, diagnostic, psychiatric, substance abuse or other Health Care Services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time We make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as

- appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

***External Independent Reviewer***

A clinical peer with no direct financial interest in connection with the Grievance/appeal in question and who has not been informed of the specific identity of the Enrollee.

***External Review***

A process, independent of all affected parties, to determine if a health care service is medically necessary or experimental/investigational.

***Full-Time Student***

An unmarried Dependent child who is between the ages of 19 – 23 that meets all the following conditions:

- The child must not be regularly employed on a full-time basis;
- The child must be primarily dependent upon the Subscriber for support and maintenance;
- The child must be attending, fulltime, a recognized course of study or training at one of the following:
  - An accredited high school;
  - An accredited college or university;
  - A licensed vocational school, technical school, beautician school, automotive school or similar training school.

Full-Time Student status is determined in accordance with the standards set forth by the educational institution. You are no longer a Full-Time Student on the date You graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-Time Student during periods of regular vacation established by the institution. If You do not continue as a Full-Time Student immediately following the period of vacation, the Full-Time Student designation will end as described above.

***Health Care Service(s)***

Those health services provided for cosmetic or other non-medical purposes, or for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse, or their symptoms, but do not include prescription drug benefits.

***Homebound***

Homebound means an individual who is confined to the home as a result of their physical or mental condition and that leaving home is a major effort and normally requires assistance. Leaving home is done to receive medical care or for short, infrequent non-medical reasons such as a trip to the grocery store, beauty parlor or barbershop, or to attend religious services.

***Home Health Agency***

A program or organization authorized by law to provide Health Care Services in the home.

***Hospital***

A legally constituted institution, having organized facilities for the care and treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under supervision of a staff of one or more licensed physicians and which provides 24-hour nursing services by registered nurses on duty or call. It does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, drug addict or alcoholic, even though such facilities are operated as a separate institution by a hospital.

***Implant(s)***

That which is implanted such as a piece of tissue, a pellet of medicine, or a tube or needle containing radioactive substance, a graft or an insert. Also included are liquid and solid materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, or diagnostic purpose. Examples of surgical implants include stents, artificial joints, shunts, grafts, pins, plates, screws, anchors and radioactive seeds.

<b><i>Infertility</i></b>	The inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful Pregnancy. (Sexual intercourse means the sexual union between a male and female). Infertility does not include individuals unable to conceive post-sterilization.
<b><i>Initial Enrollment Period</i></b>	The initial period of time, as We agree with the Enrolling Individual, during which Eligible Persons may enroll themselves and their Dependents under this Policy.
<b><i>Injury</i></b>	Bodily damage other than Sickness, including all related conditions and recurrent symptoms.
<b><i>Inpatient Mental Health</i></b>	An acute care facility for psychiatric treatment where a psychiatric physician supervises care. The patient receives care twenty-four (24) hour per day and may be on a locked unit and/or on psychiatric precautions (e.g., suicide, homicide, close observation precautions).
<b><i>Inpatient Rehabilitation Facility</i></b>	A Hospital (or a special unit of a Hospital that is designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (Physical Therapy, Occupational Therapy and/or Speech Therapy) on an inpatient basis, as authorized by law.
<b><i>Inpatient Stay</i></b>	An uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.
<b><i>Instrumental Activities of Daily Living (IADL)</i></b>	Activities related to independent living including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using the telephone.
<b><i>Intensive Outpatient Program</i></b>	Active therapeutic programming 3 ½ hours or less per session. Therapy sessions are usually two to three times per week and are a combination of group and individual work.
<b><i>Low Protein Modified Food Products</i></b>	Food products specifically formulated to have less than one (1) gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.
<b><i>Maximum Policy Benefit</i></b>	The maximum amount that We will pay for Benefits during the entire period of time that You are enrolled under this Policy issued to the Enrolling Individual. The Maximum Policy Benefit includes any amount that We have paid for Benefits under a former Policy issued to the Enrolling Individual that is replaced by the current Policy, as well as any amount that We may pay under a later Policy that replaces the Enrolling Individual's current Policy. When the Maximum Policy Benefit applies, it is described in Section 6 (Your Cost for Covered Services).
<b><i>Medical Emergency/Medical Emergency Condition</i></b>	<p>The sudden and, at the time, unexpected, onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but is not limited to:</p> <ol style="list-style-type: none"> <li>Placing the Member's health in significant jeopardy;</li> <li>Serious impairment to a bodily function;</li> <li>Serious dysfunction of any bodily organ or part;</li> <li>Inadequately controlled pain; or</li> <li>With respect to a pregnant woman who is having contractions, when <ol style="list-style-type: none"> <li>There is inadequate time to effect a safe transfer to another Hospital before delivery; or</li> <li>Transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.</li> </ol> </li> </ol>
<b><i>Medical Foods</i></b>	Products that are intended to meet the distinctive nutritional requirements of a person with a particular disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.

significant risk of a serious deterioration and/or a significant impairment that, if not treated, could seriously affect one's ability to function within his or her normal environment. Although some Health Care Services are medically acceptable, they may not be medically necessary. Health Care Services need to be (1) medically appropriate and necessary to meet the basic health needs of the Member; (2) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Covered Service; (3) consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Plan; (4) consistent with the diagnosis of the conditions; and (5) of demonstrated medical value. Medically Necessary does not include care that is provided primarily for the convenience of the Member or a health provider, or care that is rendered more frequently than that accepted as medically appropriate by the medical profession.

<b><i>Medicare</i></b>	Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.
<b><i>Member</i></b>	A Member means any Subscriber or Dependent.
<b><i>Mental Health Services</i></b>	Covered Health Services for the diagnosis and treatment of Mental Illnesses.
<b><i>Mental Health/Substance Abuse Designee</i></b>	Refers to St. John's Mercy Managed Behavioral Health or other applicable designated agent that provides and manages Mental Health Services for the Plan.
<b><i>Mental Illness</i></b>	Those illnesses and disorders listed in the International Classification of Disease Manual and the Diagnostic and Statistical Manual of Mental Disorders. Mental Illness includes substance use disorders.
<b><i>Network Benefits</i></b>	Benefits for Covered Health Services that are provided by (or directed by) a Network Physician or other Network Provider in the provider's office or at a Network or Non-Network facility.
<b><i>Network/Network Provider</i></b>	<p>When used to describe a provider of Health Care Services, this means a provider that has a participation agreement in effect with Us or with Our affiliate (directly or through one or more other organizations) to provide Covered Health Services to Covered Persons.</p> <p>A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network Provider for only some of Our products. In this case, the provider will be a Network Provider for the Health Services and products included in the participation agreement, and a Non-Network Provider for other Health Services and products. The participation status of providers will change from time to time.</p>
<b><i>Neuropsychological Testing</i></b>	Neuropsychological testing is a quantitative, comprehensive evaluation of cognitive, motor and behavioral functional abilities related to developmental, degenerative and acquired brain disorders
<b><i>Never Event</i></b>	<b><i>Errors in medical care that are inexcusable, clearly identifiable, serious, largely preventable, and of concern to both the public and healthcare providers and included on the "serious reportable events in healthcare" list compiled by the National quality Forum."</i></b>
<b><i>Non-Network Benefits</i></b>	Benefits for Covered Health Services that are provided by a Non-Network Physician or other Non-Network Provider.
<b><i>Non-Network Provider</i></b>	A Provider who is not contracted with Mercy Health Plans.
<b><i>Observation Care</i></b>	Care in the Hospital to monitor evaluate or stabilize a patient in order to determine the need for further treatment or an inpatient admission. Such Care is not considered Inpatient Care, even though the patient may be confined to a Hospital bed.

<b><i>Occupational Therapy</i></b>	Treatment of a physically or mentally disabled person through constructive activities designed to restore the ability to accomplish satisfactorily the ordinary activities of daily living. Activities of daily living include feeding, dressing, bathing and other types of self-care.
<b><i>Out-of-Pocket Maximum</i></b>	If applicable, the maximum amount of Deductible and Coinsurance You pay every Calendar Year for Eligible Expenses. If You use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once You reach the Out-of-Pocket Maximum for Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that [Calendar] [Plan] Year. Once You reach the Out-of-Pocket Maximum for Non-Network Benefits, those Benefits are payable at 100% of Eligible Expenses during the rest of that Calendar Year. See Section 6 (Your Cost for Covered Services).
<b><i>Outpatient Mental Health Visits</i></b>	Psychotherapy and other mental health services provided in an individual practitioner office. Psychotherapy may be provided by a medical doctor (MD), clinical psychologist (Ph.D.), or Master's level licensed therapist.
<b><i>Palliative Care</i></b>	Care provided to patients with progressive and advanced disease with little or no prospect of cure. A comprehensive approach to treating life-threatening illness that focuses on the physical, psychological, spiritual and existential needs of the patient. It is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as Chemotherapy or radiation therapy, and includes investigations needed to evaluate and treat clinical complications. Palliative care is meant to maintain the quality of life of patients and their families coping with the problems associated with life-threatening illness.
<b><i>Partial Hospital Treatment Program</i></b>	Active therapeutic mental health programming and care given to a patient for 3 ½ hours or more per day in a facility setting. Mental health professionals have assessed that the patient can maintain safety outside of the hospital environment during Non-program hours. During this program, the patient may or may not see psychiatrist daily depending on condition.
<b><i>Physical Therapy</i></b>	Treatment by physical means including hydrotherapy, heat, physical agents, and biomechanical and neurophysiological principles and devices that relieve pain or restore maximum bodily function. Physical Therapy does not include Cardiac Rehabilitation, Pulmonary Rehabilitation or Manipulation/Adjustment.
<b><i>Physician</i></b>	Any Doctor of Medicine, "M.D.", or Doctor of Osteopathy, "D.O.", who is properly licensed and qualified by law.  Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that We describe a provider as a Physician does not mean that Benefits for services from that provider are available to You under this Policy.
<b><i>Plan (the Plan)</i></b>	The Plan refers to Mercy Health Plans.
<b><i>Policy</i></b>	This document including all riders, Amendments and Schedule of Coverage.
<b><i>Policy Charge</i></b>	The sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under this Policy.
<b><i>Preexisting Condition</i></b>	An Injury or Sickness that was diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the twelve (12) month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under this Policy or, if earlier, the first day of any waiting period under this Policy.) Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information. Preexisting Conditions do not apply for Covered Persons with Continuous Creditable Coverage of twelve (12) months or more without a break in coverage of sixty-three (63) days or less.
<b><i>Premium</i></b>	The periodic fee required for each Subscriber and each Enrolled Dependent, in accordance

with the terms of this Policy.

<b><i>Preventive Health Screening(s)</i></b>	Routine tests performed on a healthy individual who has no signs or symptoms of disease, or history of the disease being screened. Preventive Health Screenings are for the purpose of detecting abnormalities or malfunctions of bodily systems and parts according to accepted medical practice. Tests performed on a symptomatic patient are classified as diagnostic tests.
<b><i>Prior Authorization</i></b>	Precertification review by the Plan, <u>before</u> services and treatment are rendered, to determine if the service meets the criteria as a Covered Health Service.
<b><i>Private Duty Nursing</i></b>	Private Duty Nursing is defined as one-on-one care provided on an individual basis either in an institution or in a patient's home. Private duty skilled nursing care can be considered custodial after Non-professional personnel repetitively performs the care, making continuous attention by a health professional no longer necessary, and is therefore not a covered benefit.
<b><i>Pulmonary Rehabilitation</i></b>	A comprehensive program to manage patients with substantial chronic lung disease. Includes diagnostic testing, monitored dynamic exercise and education under the direct supervision of a qualified Physician.
<b><i>Rider</i></b>	Any attached written description of additional Covered Health Services not described in this Certificate. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by Us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.
<b><i>Rolling Years</i></b>	A consecutive twelve (12) month period that begins on the date You receive a Covered Service and continues for each consecutive twelve (12) month period thereafter. A Rolling Year, for example, can be April 1 (of one year) to March 31 (of the following year); it is not the same as a Calendar Year.
<b><i>Semi-Private Room</i></b>	A room with two or more beds. When an Inpatient Stay in a Semi-Private Room is a Covered Health Service, the difference in cost between a Semi-Private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-Private Room is not available.
<b><i>Service Area</i></b>	Our Service Area includes all counties in the state of Arkansas.
<b><i>Sickness</i></b>	Physical illness or disease. The term Sickness as used in this Policy does not include Mental Illness or substance abuse, regardless of the cause or origin of the Mental Illness or substance abuse.
<b><i>Skilled Nursing Facility</i></b>	A Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility is not, other than incidentally, a place that provides minimal Care, Custodial Care, ambulatory Care, part-time Care, or Care for Mental Illness and Substance Abuse, pulmonary tuberculosis or venereal disease.
<b><i>Speech Therapy</i></b>	Treatment for loss or impairment of speech or hearing, including communicative disorders resulting from genetic defects, birth defects, injury, illness, disease, developmental disabilities or delays or other causes, whether of organic or non-organic etiology and whether or not the person suffering from that loss or impairment had the capacity for speech, language or hearing before the loss or impairment occurred.
<b><i>Spinal Treatment</i></b>	<u>The</u> detection or correction by manual or mechanical means of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.
<b><i>Spouse</i></b>	One who is legally married to an Eligible Member in a ceremony legally solemnized by a third party duly authorized by law to perform marriages.

<b><i>Standard Basic Equipment</i></b>	Equipment that is the usual or most common and simplest form that possesses the most fundamental level of function required to meet the needs of the member in performing Instrumental Activities of Daily Living.
<b><i>Subscriber</i></b>	An Eligible Person who is properly enrolled under this Policy. The Subscriber is the person (who is not a Dependent) on whose behalf this Policy is issued.
<b><i>Substance Abuse Services</i></b>	The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.
<b><i>Termination Date</i></b>	Means: <ul style="list-style-type: none"> <li>a. For the Member, the last date on which the Member is eligible for coverage; or</li> <li>b. For the Member and Dependent(s), the last date on which this Policy is in force.</li> </ul>
<b><i>Unproven Services</i></b>	<p>Services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs:</p> <ul style="list-style-type: none"> <li>• Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)</li> <li>• Well-conducted cohort studies. (Patients who receive study treatment are compared to a Individual of patients who receive standard therapy. The comparison Individual must be nearly identical to the study treatment Individual.)</li> </ul> <p>Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.</p>
<b><i>Urgent Care Center</i></b>	A facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of Your health, within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms
<b><i>Us/We/Our</i></b>	Us/We/Our refers to Mercy Health Plans.
<b><i>Usual and Customary Rate (UCR)</i></b>	<p>Charges for Covered Health Services that do not exceed the fees and prices generally approved for cases of comparable nature and severity at the time and place when such Covered Services are rendered or received. In determining the Usual and Customary Rate (UCR), one or more of the following guidelines shall be taken into consideration:</p> <ul style="list-style-type: none"> <li>a) The rate allowed by Medicare for the particular service or supply</li> <li>b) The prevailing rate of fees charged for identical or similar services in the same geographical area by health professionals of similar training and experience;</li> <li>c) Unusual circumstances or complications that require additional time, skill and experience in connection with the provided service or supply;</li> <li>d) The actual charge by the provider (if less than Our UCR charge);</li> <li>e) The frequency of the determination of the usual and customary fee;</li> <li>f) A general description of the methodology used to determine usual and customary fees;</li> <li>g) The percentile that determines the maximum benefit the Plan will pay for any Accidental Injury dental procedure, if the usual and customary fee is determined by taking a sample of fees submitted on actual claims from licensed dentists and then making the benefit by selecting a percentile of those fees.</li> </ul>

***Utilization Review***

A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency, of Health Care Services, procedures or settings. Utilization Review may include Ambulatory Review, Prospective Review, second opinion, Certification, Concurrent Review, Case Management, discharge planning or Retrospective Review, but will not include elective requests for clarification of Coverage.

***You/Your***

You/Your refers to the Subscriber and each Enrolled Dependent.

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## NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

MHP, Inc. by and on behalf of its wholly-owned subsidiaries, including Mercy Health Plans of Missouri, Inc., Mercy Health Plans, ForeSee Health, Inc., and Premier Benefits, Inc. (Collectively referred to as “We”, “Our”, or “the Plan”), respects the privacy of its Members and former Members and protects the security and confidentiality of their nonpublic personal information. We have instituted internal policies to: insure the security and confidentiality of Your personal and financial healthcare information; protect against any anticipated threats or hazards to the security or integrity of such records; and protect against unauthorized access to or use of information which could result in substantial harm or inconvenience to You. We are required by law to provide You with this Notice of Our legal duties and privacy practices. This Notice explains Your rights, Our legal duties, and Our privacy practices. To fulfill Our responsibilities to You, the Plan may use and disclose Your protected health information for treatment, payment, and healthcare operations, or when We are otherwise required or permitted to do so by law. Below is further detail explaining these situations.

**Treatment.** We may use and disclose protected health information with Your healthcare providers (physicians, pharmacies, hospitals and others) to assist in the diagnosis and treatment of Your injury or illness. For example, We may disclose Your protected health information to suggest treatment alternatives.

**Payment.** We may use and disclose protected health information to pay for Your covered health expenses. For example, We may use protected health information to process claims. We may also ask a healthcare provider for details about Your treatment so that We may pay the claim for Your care.

**Healthcare Operations.** We may use and disclose protected health information for Our healthcare operations. For example, We may use or disclose protected health information to perform quality assessment activities or provide You with Case Management services.

**Business Associates.** We may at times need to use the services of other companies in lieu of Our own staff, such as outsourcing data entry services, or, as part of Our routine business, We may require that outside entities, such as auditors perform operations that require access to Our healthcare information. In order for Us to share confidential information with these organizations, We must enter into agreements that require them to comply with the privacy regulations of the Plan.

**You or Your Personal Representative.** We must disclose Your health information to You as described in the Patient Rights Section below. If You have a legally assigned personal representative or are an unemancipated minor, We will release the information to Your personal representative or parent(s) as required by law.

**Family/Friends.** We may disclose Your health information to a family member or friend to the extent necessary to help with Your healthcare or with payment for Your healthcare if You agree that We may do so. If You wish to designate a person(s) to whom We may discuss Your healthcare, You may submit a request to the address listed below. If You are physically or mentally unable to participate in decisions regarding Your healthcare, We may need to communicate with a family member; however, only to the extent necessary to insure that You receive appropriate healthcare treatment.

**Permitted or Required by Law.** We must disclose protected health information about You when required to do so by law. Information about You may be used or disclosed to regulatory agencies, such as Medicare and Medicaid; for administrative or judicial hearings; public health authorities; or law enforcement officials, such as to comply with a court order or subpoena.

### Member Authorization

Other uses or disclosures of Your protected health information will be made only with Your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that We have already taken action on the information disclosed or if We are permitted by law to use the information to contest a claim or coverage under the Plan.

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## YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

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You have the following rights regarding protected health information that the Plan maintains about You. If You wish to exercise any of these rights, You may submit Your request in writing.

**Right to Access Your Protected Health Information.** You have the right to inspect and/or obtain a copy of individual protected health information that We maintain about You. We may charge a fee for the costs of producing, copying and mailing Your requested information, but We will tell You the cost in advance.

**Right to Amend Your Protected Health Information.** You have the right to request an amendment of individual protected health information that We maintain about You. All requests must be in writing and must include the reason for the change.

**Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of disclosures of individual protected health information made by the Plan on or after the compliance date of April 14, 2003. All requests must be in writing and must state the period of time for which You want the accounting. We may charge for providing the accounting, but We will tell You the cost in advance.

**Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that the Plan restrict the use and disclosure of Your protected health information for treatment, payment, or healthcare operations. The Plan is not required to agree to the requested restriction; however, if the Plan does agree to the restriction, it must comply with Your request unless the information is needed for an emergency.

**Right to Receive Confidential Communications.** You have the right to request to receive communication of protected health information from the Plan through an alternative procedure (other than the standard means of communicating protected health information). All requests must be in writing and are subject to technical reasonability for the Plan.

**Right to a Paper Copy of This Notice.** You have the right at any time to receive a paper copy of this Notice, even if You had previously agreed to receive an electronic copy.

### Changes

The Plan reserves the right to change the terms of this Notice at any time, effective for protected health information that We already have about You as well as any information that We receive in the future. We are required by law to comply with whatever Notice is currently in effect. We will communicate changes to Our Notice through subscriber newsletters, direct mail and/or Our Internet website ([www.mercyhealthplans.com](http://www.mercyhealthplans.com)).

### Complaints

If You believe Your privacy rights have been violated, You have the right to file a Complaint with the Plan and/or with the Federal Government. Complaints to the Plan may be directed to the appropriate Customer Contact Center listed at the end of this Notice or by calling the Customer Contact Center number listed on the back of Your ID card. You may also file a Complaint anonymously by calling the Plan's Fraud and Abuse Hotline at 1-877-349-5997. Complaints to the government may be sent to: Secretary of the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. You will not be penalized for filing a Complaint.

### Contact The Plan

If You want more information about this Notice, how to exercise Your rights, or how to file a Complaint, please direct Your correspondence to the appropriate Customer Contact Center listed at the end of this Notice or call the Customer Contact Center phone number listed on the back of Your ID card. You can also contact Us through Our Internet website: [www.mercyhealthplans.com](http://www.mercyhealthplans.com)

Mercy Health Plans  
ATTN: Customer Contact Center  
14528 S Outer 40, Suite 300,  
Chesterfield, MO 63017-5743  
(866) 450-3249

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## **NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

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Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

### **DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract. Coverage is NOT provided for Your policy or contract or any portion of it that is not guaranteed by the insurer or for which You have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract. Insurance companies or their agents are required by law to provide You with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce You to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association  
c/o The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

### **COVERAGE**

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

### **EXCLUSIONS FROM COVERAGE**

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals);

- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

#### **LIMITS ON AMOUNT OF COVERAGE**

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 — no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance Benefits, \$300,000 in present value of annuity Benefits, or \$300,000 in life insurance death Benefits or net cash surrender values — again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity Benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those Benefits could be provided out of the assets of the impaired or insolvent insurer.



## MERCY HEALTH PLANS

### SCHEDULE OF COVERAGE AND BENEFITS for

#### Effective Date of Coverage

With Mercy Health Plans' PPO, You can choose to receive either Network Benefits or Non-Network Benefits. To obtain Network Benefits You must see a Network Physician or other Network Provider. When You use Non-Network Providers, Your out-of-pocket costs are greater. You must show Your identification card (ID card) every time You request health care services from a Network Provider. If You do not show Your ID card, Network Providers have no way of knowing that You are enrolled under a Mercy Health Plans' PPO Policy. As a result, they may bill You for the entire cost of the services You receive. Note that when You receive different types of Covered Services from the same Provider and/or on the same day, You may be responsible for any applicable cost-sharing associated with each individual service or treatment.

**You will be financially responsible for any services or treatment that are not covered (excluded) by Mercy Health Plans. Please refer to Your Individual Comprehensive Health Insurance Policy (Policy), Section 13, for a detailed explanation of non-covered services. Just because a Physician or other Health Care Professional has performed, prescribed or recommended a service does not mean it is Medically Necessary or that it is covered under this Schedule of Coverage and Benefits.**

PAYMENT INFORMATION	AMOUNT	
	NETWORK	NON-NETWORK
Annual Deductible	[\$0 – 10,000] per Covered Person per Calendar Year, not to exceed [\$0 – 30,000] for all Covered Persons in a family.]	[\$0 – 10,000] per Covered Person per Calendar Year, not to exceed [\$0 – 30,000] for all Covered Persons in a family.]
Out-of-Pocket Maximum <i>The Annual Deductible and Coinsurances apply towards Your Out-of-Pocket Maximum. Coinsurance is the amount You pay after You meet Your Deductible.</i>	[\$0 – 10,000] per Covered Person per Calendar Year, not to exceed [\$0 – 30,000] for all Covered Persons in a family.] [No Out-of-Pocket Maximum]	[\$0 – 10,000] per Covered Person per Calendar Year, not to exceed [\$0 – 35,000] for all Covered Persons in a family.] [No Out-of-Pocket Maximum]
Maximum Policy Benefit	[\$1,000,000 – 5,000,000] per Covered Person.] [No Maximum Policy Benefit]	[\$1,000,000 – 5,000,000] per Covered Person.] [No Maximum Policy Benefit]

MEDICAL SERVICES (As outlined in Your Policy)	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
<b>1. Allergy</b> <ul style="list-style-type: none"> <li>Office Visits</li> <li>Injections/Treatment</li> </ul>	<i>Office Visit:</i> [\$0-\$100 Copayment] [0%-50% Coinsurance] per office visit [after Deductible] for Primary care [\$0-\$100 Copayment] [0%-50% Coinsurance] per office visit [after Deductible] for Specialist care  <i>Injections/Treatment:</i> [[\$0-\$100] Copayment] [when no charge is made for physician's services.] [0%-50%] Coinsurance after Deductible	<i>Office Visit:</i> [0% - 50%] Coinsurance after Deductible  <i>Injections/Treatment:</i> [0% - 50%] Coinsurance after Deductible
<b>2. Ambulance Services - Emergency Only</b> <ul style="list-style-type: none"> <li>Ground Transportation</li> <li>Air Transportation*</li> </ul>	<i>Ground Transportation:</i> [\$25–250 Copayment] per transport [0% - 50% Coinsurance after Deductible] [No Copayment] <i>Air Transportation:</i> [0% - 50% Coinsurance after Deductible] [\$50-500 Copayment] per transport	<i>Ground Transportation:</i> [\$25–250 Copayment] per transport [0%-50% Coinsurance after Deductible] [No Copayment] <i>Air Transportation:</i> [0% - 50% Coinsurance after Deductible] [\$50-500 Copayment] per transport

\*Requires Prior Authorization. Refer to Your Policy for details. Prior Authorization can be found at [mercyhealthplans.com](http://mercyhealthplans.com) or by calling Our Customer Contact Center at the number listed on Your ID card.

MEDICAL SERVICES (As outlined in Your Policy)	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
<b>3. Dental Anesthesia and Facility Charges*</b> Coverage is limited to: <ul style="list-style-type: none"> <li>• A child under the age of five (5); or</li> <li>• A Covered Person who is severely disabled; or</li> <li>• A Covered Person has a medical or behavioral condition that requires hospitalization or general anesthesia when dental care is provided.</li> </ul>	[0% - 50%] Coinsurance after Deductible	[0% - 50%] Coinsurance after Deductible
<b>4. Dental Services - Accident only*</b> Initial contact with a Physician or dentist must have occurred within 72 hours of the accident. In no case will accidental dental coverage extend more than 12 months from the date of injury. Any further visits for post-Emergency treatment must be pre-approved by the Plan.	[0% - 50%] Coinsurance after Deductible	[0% - 50%] Coinsurance after Deductible
<b>5. Diabetes Services*</b> Medically appropriate and necessary equipment, supplies and self-management training for the management and treatment of diabetes. Services are provided for persons with gestational, type I or type II diabetes. Coverage for diabetes self-management training is limited to one (1) program during the entire time You are covered under this Policy. See Policy, (Section 12: Covered benefits).	[Copayment/Coinsurance consistent with type of service required.] [0% - 50% Coinsurance after Deductible]	[0% - 50% Coinsurance after Deductible] [Copayment/Coinsurance consistent with type of service required.]
<b>6. Dialysis</b> Medically Necessary dialysis is a covered Benefit.	[[0%-50%] Coinsurance after Deductible]	[0% - 50%] Coinsurance after Deductible
<b>7. Durable Medical Equipment (DME) and Medical Supplies*</b> Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment [once] [every] [each] [two-five] Calendar Year[s].  Any combination of Network and Non-Network Benefits for Durable Medical Equipment is limited to [\$750-\$10,000] per [Calendar] [Rolling] [Plan] Year. This limitation is not applicable to any equipment, supplies or self-management training for the treatment of diabetes.	[0% - 50% Coinsurance after Deductible] [No Copayment]	[0% - 50%] Coinsurance after Deductible
<b>8. Emergency Room Services</b> [Physician charges may be applicable, if billed separately. See <i>Professional Fees for Surgical and Medical Services</i> below.]	[\$0-250 Copayment per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours] [0% - 50% Coinsurance after Deductible]	[\$0-250 Copayment per visit, except Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours] [0% - 50% Coinsurance after Deductible]
<b>9. Eye Examinations (Routine Only)</b> Benefits include one (1) routine vision exam, including refraction, to detect vision impairment [each] [every other] [2- 5] [Calendar] [Rolling] Year[s].	[\$5-100 Copayment per visit] [0% - 50% Coinsurance after Deductible]	[0% - 50%] Coinsurance after Deductible

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MEDICAL SERVICES (As outlined in Your Policy)	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
<b>10. Hearing Aid</b> Hearing Aids including repair and replacement parts: [Total maximum Benefit of \$1,400 net expense per ear applicable toward the purchase of hearing aids from a Network or Non-Network Provider every three (3) [Calendar] [Rolling] Rolling] Years [thirty-six (36) consecutive months].  [This mandated offer is not subject to any Deductible, Coinsurance or copayment.]	[0% - 50% Coinsurance, No Deductible]  [Specialist Copayment for annual hearing test will apply. If hearing test is done in conjunction with an office visit, only one copayment applies.]  [Coinsurances will be counted in Your Out-of-Pocket Maximum]  [Coverage not available.]  Coverage of hearing aids is not subject to any Deductible, Coinsurance or Copayment. [Hearing Testing: [Specialist Copayment] [Coinsurance after Deductible] for annual hearing test will apply. [If hearing test is done in conjunction with an office visit, only one Copayment applies.]]	[0% - 50% Coinsurance, No Deductible]  [Specialist Copayment for annual hearing test will apply. If hearing test is done in conjunction with an office visit, only one copayment applies.]  [Coinsurances will be counted in Your Out-of-Pocket Maximum]  [Coverage not available.]  Coverage of hearing aids is not subject to any Deductible, Coinsurance or Copayment. [Hearing Testing: Coinsurance after Deductible for annual hearing test will apply.]
<b>11. Home Health Care*</b> Services provided by a Home Health Agency must be: <ul style="list-style-type: none"> <li>• Ordered by a physician;</li> <li>• Provided by or supervised by a registered nurse in Your home; and</li> <li>• You are Homebound or Your physical or mental condition pose a serious and significant impediment to receiving medically necessary services outside the home.</li> </ul> Any combination of Network and Non-Network Benefits for home health care is limited to 60 visits per [Calendar] [Rolling] [Plan] Year.	[\$0-100 Copayment per visit] [0% - 50% Coinsurance after Deductible] [No Copayment]	[0% - 50%] Coinsurance after Deductible
<b>12. Hospice/Palliative Care*</b> Any combination of Network and Non-Network Benefits is limited to 180 days lifetime maximum.	[\$0 – 100 Copayment per day] [0% - 50% Coinsurance after Deductible] [No Copayment]	[0% - 50%] Coinsurance after Deductible
<b>13. Immunization - Routine Only</b> (Received in Physician's Office)	[\$5-75] [Copayment per visit] [0% - 50% Coinsurance][after Deductible] for adults over 18 yrs.] [per injection] [No Copayment] No Copayment, Coinsurance or Deductible for immunizations for children birth through age 18 yrs.	[0% - 50% Coinsurance] [after Deductible] [per injection] for adults over 18 yrs.] [Covered In Network Only] [No Copayment, Coinsurance or Deductible for immunizations for children birth through age 18 yrs.]
<b>14. Injectable /Infusions*</b> (Received in a physician's office, infusion center or through home health)	[0% - 50%] Coinsurance [after deductible] [\$0-100 Copayment] [per injectable/infusion] [No Copayment] [No office visit Copayment applies when a Physician charge is not assessed]	[0% - 50%] Coinsurance after deductible per injectable/infusion
<b>15. Inpatient Hospital Services*</b> Semi-private room covered.	[0% - 50% Coinsurance after Deductible] [\$0-\$5000 Copayment per Inpatient Stay] [\$0-1,000] Copayment per day] [\$0-1,000] Copayment per day to a maximum of [\$0-5,000] Copayment per Inpatient Stay]	[0% - 50%] Coinsurance after Deductible

\*Requires Prior Authorization. Refer to Your Policy for details. Prior Authorization can be found at [mercyhealthplans.com](http://mercyhealthplans.com) or by calling Our Customer Contact Center at the number listed on Your ID card.

MEDICAL SERVICES (As outlined in Your Policy)	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
<b>16. Mental Health and Substance Abuse Services – Outpatient*</b>  Any combination of Network and Non-Network Benefits is limited to [20 – 30] visits per [Calendar] [Plan] Year.  Any combination of Network and Non-Network Benefits for Mental Health and Substance Abuse Services for Outpatient is limited to [\$750-\$10,000] per [Calendar] [ Rolling] [Plan] Year.	[0% - 50% Coinsurance after Deductible] [No Copayment] [[0-\$100] per visit]	[0% - 50%] Coinsurance after Deductible
<b>17. Mental Health and Substance Abuse Services – Inpatient and Intermediate*</b> Any combination of Network and Non-Network Benefits is limited to [7 – 30] days per [Calendar] [Plan] Year.  Any combination of Network and Non-Network Benefits for Mental Health and Substance Abuse Services – Inpatient and Intermediate is limited to [\$750-\$10,000] per [Calendar] [ Rolling] [Plan] Year.	[0% - 50% Coinsurance after Deductible] [No Copayment] [\$0-1,000] per day to a maximum of [\$0-5,000] per Inpatient Stay]	[0% - 50%] Coinsurance after Deductible
<b>18. Newborn Child Coverage*</b>	[0% - 50% Coinsurance after Deductible] [\$0-\$5000 per Inpatient Stay] [\$0-1,000] Copayment per day [\$0-1,000] Copayment per day to a maximum of [\$0-5,000] per Inpatient Stay] [No Copayment]	[0% - 50%] Coinsurance after Deductible
<b>19. Nutritional Counseling</b> Up to three (3) visits in a [Calendar] [Rolling] [Plan] Year for only certain conditions.	[0% - 50% Coinsurance after Deductible] [\$0-100 Copayment per visit]	[0% - 50%] Coinsurance after Deductible
<b>20. Observation Care*</b> Coverage for up to forty-eight (48) hours at the designated Copayment.	[0% - 50%] Coinsurance after Deductible	[0% - 50%] Coinsurance after Deductible
<b>21. Orthotics</b> [Benefits for orthotic devices are limited to the single purchase of each type of orthotic device [every] [each] [two-five] [Calendar] [Rolling] [Plan] Year(s).]  Any combination of Network and Non-Network Benefits for prosthetic devices is limited to [\$750-\$10,000] per [Calendar] [Rolling] [Plan] Year. Orthotics devices/equipment in excess of \$1,000.00 must be approved in advance by the Plan.	[0% - 50%] Coinsurance after Deductible	[0% - 50%] Coinsurance after Deductible
<b>22. Osteoporosis Services/Bone Mineral Density (BMD) Testing*</b> Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under <i>Professional Fees for Surgical and Medical</i>	[0% - 50%] Coinsurance after Deductible	[0% - 50%] Coinsurance after Deductible

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MEDICAL SERVICES (As outlined in Your Policy)	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
<p><i>Services below.</i></p> <p>[When these services are performed in a Physician's office, Benefits are described under <i>Physician Office Services</i> above.]</p>		
<p><b>23. Outpatient Diagnostic Services*</b></p> <p>Covered health services received on an outpatient basis at a Hospital or Alternate Facility include:</p> <ul style="list-style-type: none"> <li>Laboratory services</li> <li>X-Ray/Imaging</li> <li>Other diagnostic &amp; therapeutic services</li> </ul> <p>[When some lab and x-ray services are performed in a Physician's office, physician's charges may apply. See Physician's Office Services below.]</p> <p>[Regardless of the place where these services are performed the cost-sharing for outpatient diagnostics will apply.]</p> <p>The following services are subject to the outpatient diagnostic cost-sharing, regardless of the place of service:</p> <ul style="list-style-type: none"> <li>MRA</li> <li>MRI</li> <li>CT Scan</li> <li>PET Scan</li> <li>Nuclear Cardiology Imaging studies</li> </ul>	<p><u>Laboratory services:</u> [0%-50% Coinsurance] [after Deductible] [no Deductible] [No Copayment]</p> <p><u>X-ray/Imaging:</u> [0% - 50% Coinsurance] [after Deductible] [no Deductible] [No Copayment]</p> <p><u>Other diagnostic/therapeutic services:</u> [[0% - 50%] Coinsurance after Deductible]</p> <p>[Regardless of the place where these services are performed the cost-sharing for outpatient diagnostics will apply.]</p> <p><u>MRA ,MRI, CT Scan, PET Scan, and Nuclear Cardiology Imaging studies:</u></p> <p>[0%-50%] Coinsurance after Deductible</p>	<p><u>Laboratory services:</u> [[0 - 50%] Coinsurance after Deductible]</p> <p><u>X-ray/Imaging:</u> [[0 - 50%] Coinsurance after Deductible]</p> <p><u>Other diagnostic/therapeutic services:</u> [[0 - 50%] Coinsurance after Deductible]</p> <p>[Regardless of the place where these services are performed the cost-sharing for outpatient diagnostics will apply.]</p> <p><u>MRA ,MRI, CT Scan, PET Scan, and Nuclear Cardiology Imaging studies:</u></p> <p>[0% - 50%] Coinsurance after Deductible</p>
<p><b>24. Outpatient Surgery/Hospital Procedures*</b></p> <p><i>Coverage includes surgical services and Hospital procedures received on an outpatient basis at a Hospital or Alternate Facility.</i></p> <ul style="list-style-type: none"> <li><b>Surgical Implants</b> Implants for cosmetic or psychological reasons are excluded; see Section 13, K. in Your Policy.</li> </ul> <p>[Any combination of Network and Non-Network Benefits for surgical Implants is limited to [\$2,500-\$10,000] per [Calendar] [Rolling] [Plan] Year.]</p>	<p>[\$0 – 1,000 Copayment] [per surgical procedure] for outpatient surgery.] [[0% - 50% Coinsurance after Deductible] [No Copayment]</p> <p><u>Surgical Implants:</u> [Copayment consistent with type of service required.] [0% - 50% Coinsurance after Deductible]</p>	<p>[0% - 50%] Coinsurance after Deductible</p> <p><u>Surgical Implants:</u> [Copayment consistent with type of service required.] [0% - 50% Coinsurance after Deductible]</p>
<p><b>25. Physician's Office Services</b></p>	<p>[\$10-100 Copayment per visit] [to a PCP] [to a Specialist] [No office visit Copayment applies when no Physician charge is assessed.] [0% – 50% Coinsurance after Deductible]</p>	<p>[0% - 50%] Coinsurance after Deductible</p>
<p><b>26. PKU Formula and Medical Foods for Metabolic Disorders</b></p> <p>Coverage for the treatment of phenylketonuria (PKU) or any inherited disease of amino and organic acids. To be eligible for coverage, the cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons must exceed two thousand four hundred dollars (\$2,400)/year per person.</p>	<p>[0% - 50%] [Coinsurance after deductible] [No Copayment]</p>	<p>[0% - 50%] Coinsurance after deductible</p>
<p><b>27. Preventive Health Screenings – Routine Only</b></p>	<p><u>Cholesterol Tests:</u> [[0% – 50% Coinsurance] [No Deductible] [when provided In Network Only]]</p>	<p><u>Cholesterol Tests:</u> [[0% – 50% Coinsurance after Deductible]</p>

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MEDICAL SERVICES (As outlined in Your Policy)	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
<p>Services may be performed in a Physician's Office or an Outpatient Facility and may incur both a professional fee and/or Outpatient facility charges. [Copayment will be consistent with type of service required.]</p> <p>[Benefits under this section include only the facility charge and the charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under Professional Fees for Surgical and Medical Services below.]</p> <p>[When these services are performed in a Physician's office, Benefits are described under Physician Office Services above.] [Regardless of the place where these services are performed the applicable cost-sharing will apply.]</p>	<p>[No Copayment] [Not Applicable] [0% - 50% Coinsurance after Deductible]</p> <p><i>Colonoscopy:</i> [[0% – 50% Coinsurance] [No Deductible] [when provided In Network Only] [No Copayment][Not Applicable] [0% - 50% Coinsurance after Deductible]</p> <p><i>Double-contrast Barium Enema:</i> [[0% – 50% Coinsurance] [No Deductible] [when provided In Network Only] [No Copayment][Not Applicable] [0% - 50% Coinsurance after Deductible]</p> <p><i>Fecal Occult Blood Test:</i> [[0% – 50% Coinsurance] [No Deductible] [when provided In Network Only] [No Copayment][Not Applicable] [0% - 50% Coinsurance after Deductible]</p> <p><i>Flexible Sigmoidoscopy:</i> [[0% – 50% Coinsurance] [No Deductible] [when provided In Network Only] [No Copayment][Not Applicable] [0% - 50% Coinsurance after Deductible]</p> <p><i>Mammography:</i> [[0% – 50% Coinsurance] [No Deductible] [when provided In Network Only] [No Copayment][Not Applicable] [0% - 50% Coinsurance after Deductible]</p> <p><i>Pap/Pelvic:</i> [[0% – 50% Coinsurance] [No Deductible] [when provided In Network Only] [\$10-100 per visit] [to a PCP] [to a Specialist] [No Copayment] [Not Applicable] [0% - 50% Coinsurance after Deductible]</p> <p><i>Prostate Exam:</i> [[0% – 50% Coinsurance] [No Deductible] [when provided In Network Only] [No Copayment] [Not Applicable] [0% - 50% Coinsurance after Deductible]</p> <p><i>PSA Test:</i> [0% – 50% Coinsurance] [No Deductible when provided In-Network only] [No Copayment] [0% - 50% Coinsurance after Deductible]</p>	<p>[Not Applicable] [Covered In Network Only]</p> <p><i>Colonoscopy:</i> [[0% - 50%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only] [[0% - 50%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p><i>Double-contrast Barium Enema:</i> [[0% - 50%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p><i>Fecal Occult Blood Test:</i> [[0% - 50%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p><i>Flexible Sigmoidoscopy:</i> [[0% - 50%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p><i>Mammography:</i> [[0 - 50%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p><i>Pap/Pelvic:</i> [[0% - 50%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p><i>Prostate Exam:</i> [[0% - 50%] [Coinsurance after Deductible] [Not Applicable] [Covered In Network Only]</p> <p><i>PSA Test:</i> [0 – 50% Coinsurance after Deductible] [Not Applicable]</p>
<b>28. Professional Fees for Surgical and Medical Services</b>	[0% - 50%] Coinsurance after Deductible	[0% - 50%] Coinsurance after Deductible
<p><b>29. Prosthetics*</b> [Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device [every] [two-five] [Calendar] [Rolling] [Plan] Year(s).]</p> <p>Any combination of Network and Non-Network Benefits for prosthetic devices is limited to [\$2,500-\$10,000] per [Calendar] [Rolling] [Plan] Year. Please note that this limitation does not apply to breast prostheses.</p>	[0% - 50%] Coinsurance after Deductible	[0% - 50%] Coinsurance after Deductible

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MEDICAL SERVICES (As outlined in Your Policy)	MEMBER RESPONSIBILITY	
	NETWORK	NON-NETWORK
<b>30. Reconstructive Procedures*</b> Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly.	[0% - 50%] Coinsurance after Deductible	[0% - 50%] Coinsurance after Deductible
<b>31. Rehabilitation Services Outpatient Therapy</b> Any combination of Network and Non-Network Benefits is limited as indicated as follows: <ul style="list-style-type: none"> <li>• [0 – 100] visits combined for Physical, Occupational, or Therapy per Calendar Year OR</li> <li>• [10 – 100] visits of Physical Therapy per [Calendar] [Rolling] [Plan] Year.</li> <li>• [10 – 100] visits of Occupational Therapy per [Calendar] [Rolling] [Plan] Year. OR</li> <li>• [10 – 100] visits of Speech Therapy per [Calendar] [Rolling] [Plan] Year. OR</li> <li>• [10 – 100] visits of Pulmonary Rehabilitation therapy within a 12-week period per [Calendar] [Rolling] [Plan] Year. OR</li> <li>• [10 – 100] visits of Cardiac Rehabilitation therapy within a 12-week period per</li> </ul> <b>Inpatient Rehabilitation Services *</b> <ul style="list-style-type: none"> <li>• Any combination of Network and Non-Network Benefits is limited up to a maximum of [60 – 120] days per [Calendar] [Plan] Year.</li> </ul>	[\$0-100 Copayment per visit] [0% - 50% Coinsurance after Deductible] [No Copayment]	[0% - 50%] Coinsurance after Deductible
<b>32. Skilled Nursing Facility (SNF)*</b> Any combination of Network and Non-Network Benefits is limited to [40-180] days per [Calendar] [Rolling] [Plan] Year.	[0% – 50% Coinsurance after Deductible] [\$0 - 5,000] per Inpatient Stay. No Copayment applies if You are transferred to a Skilled Nursing Facility or Inpatient Rehabilitation Facility directly from an acute facility.] [\$0 - 1,000] per day]	[0% - 50%] Coinsurance after Deductible
<b>33. Spinal Manipulation</b> Limited to [2-26] visits per [Calendar] [Rolling] [Plan] Year.	[\$0 - \$100 Copayment] [0% - 50% Coinsurance after Deductible]	[0% - 50%] Coinsurance after Deductible
<b>34. Tobacco Cessation Education Program</b>	[\$0-\$75 Copayment per program] [0% – 50% Coinsurance after Deductible] [No Copayment]	[0% - 50%] Coinsurance after Deductible
<b>35. Transplant Services*</b> There are specific guidelines regarding Benefits for transplant services. Call Our Contact Center at the telephone number on Your ID card for information about these guidelines.	[0% - 50% Coinsurance after Deductible] [\$0 - 5,000] per Inpatient Stay] [\$[0 - 1,000] per day] [\$0 - 1,000] per day to a maximum of [\$0 – 5000], per Inpatient Stay]	[0% - 50%] Coinsurance after Deductible ]
<b>36. Urgent Care Center Services</b> Covered Health Services received at an Urgent Care Center that are required to prevent serious deterioration of Your health within twenty-four (24) hours of the onset of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.	[\$0 –200 Copayment per visit] [0% - 50% Coinsurance after Deductible] [No Copayment]	[\$0 –200] Copayment per visit] [0% - 50% Coinsurance after Deductible]

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OPTIONAL RIDERS		
<b>[Birth Control Services]</b> [Required only if Prescription Drug Services covered.]	[Contraceptives (oral, topical, injectable), intrauterine devices (IUDs), and insertion and routine removal of implantable contraceptives (no more than once every [three (3) [Calendar] [Rolling] Years] [thirty-six (36) consecutive months], unless Medically Necessary.)  [Copayment/Coinsurance after Deductible consistent with type of service received.] [Only] [Deductibles.] [Coinsurances] [and Copayments] for [medical] [and pharmacy] services will be counted in Your Out-of-Pocket Maximum.]	
<b>[Family Services]</b>	[Tubal ligations and vasectomies.] [Copayment consistent with services received.] [Only] [Deductibles.] [Coinsurances] [and Copayments] for [medical] [and pharmacy] services will be counted in Your Out-of-Pocket Maximum.]	
<b>[Outpatient Prescription Drug]</b>	<p><b>NETWORK:</b></p> <ul style="list-style-type: none"> <li>• [[\$0-\$1,000] Annual Drug Deductible [per Member] [per Family] per Calendar Year]</li> <li>• [[\$0-\$3,000] [per Member] [per Family] annual Maximum]</li> <li>• [No Annual Drug Deductible]</li> <li>• [\$0-\$1,500 annual Benefit maximum]</li> <li>• [\$0-\$100] [0-50%] [Copayment for up to a 30-day supply of Tier One drugs]</li> <li>• [\$0-\$100] [0-50%] [Copayment for up to a 30-day supply of Tier Two drugs]</li> <li>• [[\$0-\$100] [0-50%] [Copayment for up to a 30-day supply of Tier Three drugs]</li> <li>• [[\$0-\$250] [0%-50%] Coinsurance [with a maximum of] [\$75-\$250] for up to a thirty (30) day supply for Tier Four drugs.]</li> </ul> <p>■ <b>[Mail order:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> [0%-50% Coinsurance] [1x, 2x, 2.5x, 3x Copayment] for up to a 90-day supply of Tier One drugs.]</li> <li><input type="checkbox"/> [0%-50% Coinsurance] [1x, 2x, 2.5x, 3x Copayment] for up to a 90-day supply of Tier Two or Tier Three drugs.]</li> <li><input type="checkbox"/> Mail order is not available for any Tier Four drugs.]</li> </ul> <ul style="list-style-type: none"> <li>• <b>[Tobacco Cessation:</b> Copayment will be consistent with Your Prescription drug benefit for each month's purchase up to three (3) months of coverage per benefit year for certain tobacco cessation products.]</li> <li>• [Mail order [1x, 2x, 2.5x, 3x] Copayment]</li> <li>• [90-day Retail Pharmacy [1x, 2x, 2.5x, 3x] Copayment]</li> </ul> <p><b><u>Service Charge for Brand-Name Drugs When a Generic is Available</u></b>          [If a Brand-name Drug is dispensed when a Generic equivalent that is subject to a Maximum Allowable Cost is available, the Member pays the Generic Copayment <u>plus</u> a Service Charge. A Service Charge is equal to the difference between the cost of the Brand-name drug and the cost of the Generic substitute, reflected by the Maximum Allowable cost. The Member pays a Service Charge whether he or she chooses to receive the Brand-name drug or the Prescriber requests that the Brand-name drug be dispensed when a Generic equivalent is available. (MAC A)]</p> <p>[If the Prescriber specifies a Brand-name drug must be dispensed when a Generic equivalent that is subject to a Maximum Allowable Cost is available, the Member pays the Brand-name Copayment, but does <u>not</u> pay a Service Charge. If the Member requests the Brand-name drug be dispensed when a Generic equivalent that is subject to a Maximum Allowable cost is available, the Member pays the Generic Copayment plus a Service Charge. A Service Charge is equal to the difference between the cost of the Brand-name drug and the cost of the Generic substitute, reflected by the Maximum Allowable Cost. (MAC B)]</p> <p>[If the Prescriber or the Member requests a Brand-name drug be dispensed when a Generic equivalent is available, the Member pays his or her Brand-name Copayment, but does not pay a Service Charge. (MAC C)]</p> <p><b><u>NON-NETWORK:</u></b>          The greater of 50% Coinsurance of the retail cost of a Prescription Drug or the Network Copayment/Coinsurance including any applicable Service Charge [subject to Plan Annual Drug Deductible] for up to a 30-day supply per Prescription Order or Refill.</p>	
<b>[Temporomandibular Joint Disorder (TMJ)]</b>	<b>NETWORK</b>	<b>NON-NETWORK</b>

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## OPTIONAL RIDERS

<p>[When these services are performed in a Physician's office, Benefits are described under <i>Physician Office Services</i> above.]</p> <p>[Copayment/Coinsurance consistent with applicable inpatient hospital, outpatient, hospital or other services required.]</p>	<p>[0% - 50%] Coinsurance after Deductible [\$10-100 Copayment per visit] [to a Specialist]</p> <p>[Copayment/Coinsurance consistent with type of service required]</p>	<p>[0% - 50%] Coinsurance after Deductible</p> <p>[Copayment/Coinsurance consistent with type of service required]</p>
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# MercyOne Application Checklist

Please follow this checklist to ensure your application is complete and avoid unnecessary underwriting delays.

- ☐ Complete the General Member Information section (page \*). Include the name, gender, height, weight, social security number, and date of birth for every person applying for coverage.
- ☐ Request an effective date on (page \*). You may select either the 1<sup>st</sup> or 15<sup>th</sup> of the month.
- ☐ Obtain and send to Mercy Health Plans a copy of any Certificate of Creditable Coverage, if you have had prior health insurance coverage through another carrier. We will need a copy of this Certificate in order to grant you a waiver for any pre-existing conditions.
- ☐ Select the plan option for which you will be applying (page \*).
- ☐ Answer all Health History questions (page \* and \*). Also, list all prescriptions and over-the-counter medications taken for each person applying for coverage. Failure to answer these questions will delay the underwriting of your application.
- ☐ Give us complete details in the attached *Secondary Health Questionnaire*, if you answered “yes” to any Health History conditions listed on page \* (question # 6). The page number(s) listed next to the condition(s) in this section refer to corresponding questions in the *Secondary Health Questionnaire*.
- ☐ List the primary care physician, phone number, and date of last visit for each person applying for coverage (page\*).
- ☐ Sign and date the Authorization to Use and Disclose Protected Health Information (page\*). This applies to each enrolling Applicant age 18 or over. **If your application is dated more than 60 days before the requested effective date, you will be asked to re-apply.**
- ☐ Complete the Payment Information (page \*). Payment for this policy can be made by automatic withdrawal from a checking or savings account. Mercy Health Plans also accepts Visa, MasterCard or American Express credit card payments.

If you need assistance in completing your application, please contact your agent. If you do not have an agent, please contact the MercyOne Sales Department (501) 372-0065 or (800) 330-8293, or email: [mercyconearkansas@mercy.net](mailto:mercyconearkansas@mercy.net).



Mercy Health Plans  
521 President Clinton Avenue • Suite 700  
Little Rock, AR 72201  
(501) 372-0065 • 800-330-8293  
www.mercyhealthplans.com

# Individual Application for Comprehensive Health Insurance



Please complete in black only.

## Application Type

**Coverage Information (Select One):** ☐ New Coverage \_\_\_\_\_ Effective Date Requested: \_\_\_\_/\_\_\_\_/\_\_\_\_  
☐ Change to current plan Member Number: \_\_\_\_\_ Effective Date of Change: \_\_\_\_/\_\_\_\_/\_\_\_\_  
☐ Add dependent (s) to current coverage Member Number: \_\_\_\_\_ Effective Date of Change: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Applicant Information

Please enter the following applicant information: (If applying for *Child Only Coverage*, record the child's information in the following section. Please submit a separate application for each Child Only Applicant.)

**NAME:** First Middle Last **Subscriber's Occupation:** \_\_\_\_\_  
**HOME ADDRESS:** (Street & P.O. Box if applicable) City State Zip County

**Home Phone:** (\_\_\_\_\_) \_\_\_\_\_ **Best time to call:** ☐ Day ☐ Evening **E-mail (this will not be shared with a 3rd party):** \_\_\_\_\_  
**Work Phone:** (\_\_\_\_\_) \_\_\_\_\_ **Cell Phone #:** (\_\_\_\_\_) \_\_\_\_\_

Are you a United States citizen? ☐ Yes ☐ No  
If "No", do you possess a Green Card (Permanent Resident Card) or a temporary U.S. visa? ☐ Yes ☐ No If "No", please explain: \_\_\_\_\_

Are you a legal resident of the state of Arkansas? ☐ Yes ☐ No If "No", please explain: \_\_\_\_\_

Have you resided in the United States for the past six (6) consecutive months? ☐ Yes ☐ No

## General Member Information

Please complete information below for all family members applying for coverage (attach other pages, if needed).

Name			Relationship to Applicant	Sex M/F	Height		Weight Lbs.	SSN#	Date of Birth (mm/dd/yyyy)		
First	MI	Last			Ft.	In.					
			Self								
			Spouse								
			Child								
			Child								
			Child								
			Child								
			Child								

Will the Mercy Health Plans' coverage that you are applying for **replace** or **change** your current hospital, medical or major medical insurance? ☐ Yes ☐ No

Will any applicants be **continuing** any other health insurance? ☐ Yes ☐ No If 'Yes', list name(s) : \_\_\_\_\_

## Producer Information

If you have a Producer (Broker or Agent) that will be assigned to your account, HAVE HIM/HER COMPLETE THIS SECTION.

**Note:** Mercy Health Plans (MHP) may share medical information with the Producer concerning you or your covered dependents that is contained in this application or discovered in the course of processing the application. The writing (and any assisting) Producer's current Arkansas health insurance license must be on file with MHP prior to acceptance of this application.

Do you know of any significant medical information relating to the applicant or any of his dependents that has not been reported on this form?

Yes ☐ No ☐

For purposes of processing commission, please provide the following information\*:

Agency Name: \_\_\_\_\_

Broker's Name: \_\_\_\_\_

Broker's Telephone # : \_\_\_\_\_

Broker's Email: \_\_\_\_\_

Broker's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Notification: Broker Only ☐ (Broker to receive policy)

Broker and Subscriber ☐ (Member to receive policy, Broker to receive copy by email)

\* Please fill out this information as it appears on your W-9 form.

## Coverage and Benefit Selection

To choose the type of coverage that you would like, select ONE option from EACH of the sections numbered 1, 2, 3 and 4 below.

- 1) **TYPE OF COVERAGE:** ☐ Applicant only (Ages 19-65 yrs.) ☐ Child Only (Age 6 mos -18 yrs) ☐ Applicant & spouse  
☐ Applicant & unmarried children\* ☐ Applicant, spouse & unmarried children\*

*\*Unmarried children under age 19, or who are full time students (FTS) through the date on which they turn 23 may be added to the plan. FTS documentation must accompany application. Call us for details on FTS documentation at [(501) 372-0065] [or] [800-330-8293].*

- 2) **EFFECTIVE DATE REQUESTED:** \_\_\_\_/\_\_\_\_/\_\_\_\_ [1<sup>st</sup> or 15<sup>th</sup> of the month only]

**Note: The actual effective date will be determined by Mercy Health Plans, and if approved, you will be notified of the effective date for your policy.**

- 3) **OPTIONAL RIDERS:** **Family Services Rider** [(tubal ligations & vasectomies)] – Additional \$ \_\_\_\_ /month (per family) (Applies only to Applicant and enrolled spouse) ☐ Yes ☐ No

**Temporomandibular Joint Disorder (TMJ) Rider** – Additional \$ \_\_\_\_ /month/per applicant ☐ Yes ☐ No

- 4) **PLAN SELECTION: Plan Option** – Choose ONLY ONE Plan option

Plan	In network deductible Individual/Family	In network co- insurance after Deductible	Office Visit PCP/Specialist	Prescription Copay
<input type="checkbox"/> <b>ARK - A - 10</b>	\$1,000/\$2,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> <b>ARK - B - 10</b>	\$2,500/\$5,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> <b>ARK - C - 10</b>	\$5,000/\$10,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> <b>ARK - D - 10</b>	\$1,500/\$3,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> <b>ARK - E - 10</b>	\$1,000/\$2,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> <b>ARK - F - 10</b>	\$2,500/\$5,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> <b>ARK - G - 10</b>	\$5,000/\$10,000	20%	20% after deductible	\$10/\$35/\$70

Other Health Coverage		Yes	No																
Answer "Yes" or "No" and list and/or submit additional information as requested below.																			
1) Are you or anyone that is applying for coverage currently eligible for Medicare? If "yes", please list name(s): _____  <b>Note: Anyone who is eligible for Medicare is not eligible for coverage under this Policy.</b>		<input type="checkbox"/>	<input type="checkbox"/>																
2) Have you ever had your coverage through Mercy Health Plans terminated for failure to pay premiums? If "yes", please list name(s): _____ If your coverage was terminated by Mercy Health Plans for non-payment of premiums, you must wait 12 months before applying for coverage and one month's advance premium may be required.		<input type="checkbox"/>	<input type="checkbox"/>																
3) Did you and/or your spouse and/or your eligible dependents have creditable coverage from a health insurance carrier within the past 63 days? (Creditable Coverage is any health insurance except a short term policy) If "yes", you may be eligible for pre-existing credit. If applicable, submit a copy of the Certificate of Creditable Coverage for each person applying.		<input type="checkbox"/>	<input type="checkbox"/>																
Lifestyle		Yes	No																
Answer "Yes" or "No" and list additional information as requested below.																			
1) Have you or any family member(s) who are applying for coverage smoked tobacco within the last 12 months? If "yes", list name(s): _____  Note: Additional testing may be required to confirm this information.		<input type="checkbox"/>	<input type="checkbox"/>																
2) Have you or any family member(s) who are applying for coverage used other smokeless tobacco products within the last 12 months? If "yes", list name(s): _____  Note: Additional testing may be required to confirm this information.		<input type="checkbox"/>	<input type="checkbox"/>																
3) Do you or any family member(s) who are applying for coverage use alcohol or illicit/recreational drugs? If yes, complete below:: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Name</th> <th style="width: 40%;">Which do you/family member drink/use?</th> <th style="width: 35%;">How often do you/family member drink/use?</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td> <input type="checkbox"/> Alcohol  <input type="checkbox"/> Illicit Drugs  <input type="checkbox"/> Both alcohol &amp; drugs               </td> <td> <input type="checkbox"/> Seldom  <input type="checkbox"/> Occasionally  <input type="checkbox"/> Daily               </td> </tr> <tr> <td>_____</td> <td> <input type="checkbox"/> Alcohol  <input type="checkbox"/> Illicit Drugs  <input type="checkbox"/> Both alcohol &amp; drugs               </td> <td> <input type="checkbox"/> Seldom  <input type="checkbox"/> Occasionally  <input type="checkbox"/> Daily               </td> </tr> <tr> <td>_____</td> <td> <input type="checkbox"/> Alcohol  <input type="checkbox"/> Illicit Drugs  <input type="checkbox"/> Both alcohol &amp; drugs               </td> <td> <input type="checkbox"/> Seldom  <input type="checkbox"/> Occasionally  <input type="checkbox"/> Daily               </td> </tr> </tbody> </table>		Name	Which do you/family member drink/use?	How often do you/family member drink/use?	_____	<input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit Drugs <input type="checkbox"/> Both alcohol & drugs	<input type="checkbox"/> Seldom <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily	_____	<input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit Drugs <input type="checkbox"/> Both alcohol & drugs	<input type="checkbox"/> Seldom <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily	_____	<input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit Drugs <input type="checkbox"/> Both alcohol & drugs	<input type="checkbox"/> Seldom <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily	<input type="checkbox"/>	<input type="checkbox"/>				
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4) Have you or any family member(s) who are applying for coverage used alcohol or illicit/recreational drugs in the past? If yes, complete below <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Name</th> <th style="width: 75%;">When did you/family member stop using alcohol?</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____ / _____ (mm/yyyy)</td> </tr> <tr> <td>_____</td> <td>_____ / _____ (mm/yyyy)</td> </tr> <tr> <td>_____</td> <td>_____ / _____ (mm/yyyy)</td> </tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Name</th> <th style="width: 75%;">When did you/family member stop using illicit drugs?</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____ / _____ (mm/yyyy)</td> </tr> <tr> <td>_____</td> <td>_____ / _____ (mm/yyyy)</td> </tr> <tr> <td>_____</td> <td>_____ / _____ (mm/yyyy)</td> </tr> </tbody> </table>		Name	When did you/family member stop using alcohol?	_____	_____ / _____ (mm/yyyy)	_____	_____ / _____ (mm/yyyy)	_____	_____ / _____ (mm/yyyy)	Name	When did you/family member stop using illicit drugs?	_____	_____ / _____ (mm/yyyy)	_____	_____ / _____ (mm/yyyy)	_____	_____ / _____ (mm/yyyy)	<input type="checkbox"/>	<input type="checkbox"/>
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_____	_____ / _____ (mm/yyyy)																		
_____	_____ / _____ (mm/yyyy)																		
_____	_____ / _____ (mm/yyyy)																		

[illegible]

5) List Primary Care Physician, phone number and date of last visit for each person applying:

Name of Applicant:	Primary physician name, phone number, city & state:	Date of last visit:

6) Do you or any family member(s) applying for coverage currently have or have ever been diagnosed or treated for any health conditions or diseases (either Inpatient, Outpatient or Emergency Room) pertaining to the following organ systems or diseases?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

**Check “Yes” or “No” for all conditions listed below as they apply for any covered family member.**

**NOTE:** If you answer “Yes” to any of these screening questions, you must also answer the **Secondary Health Questionnaire** related to those conditions. The page numbers listed below refer to related questions in the attached *Secondary Health Questionnaire*.

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Diabetes/Sugar in Urine/Abnormal Blood Sugar/Pre-Diabetes, [pg * ]	<input type="checkbox"/>	<input type="checkbox"/>	10. Nervous System/Brain Disorder/Headache/Epilepsy/Seizure Disorder, [pg*]
<input type="checkbox"/>	<input type="checkbox"/>	2. Endocrine/Thyroid/Pituitary/Adrenal, [pg * ]	<input type="checkbox"/>	<input type="checkbox"/>	11. Mental or Psychiatric Condition/Depression/Behavioral (e.g., Attention-Deficit Hyperactivity Disorder)or Eating Disorder, [pg*]
<input type="checkbox"/>	<input type="checkbox"/>	3. High Blood Pressure/Hypertension, [pg * ]	<input type="checkbox"/>	<input type="checkbox"/>	12. Back or Neck Disorder/Lumbago/Disc Herniation or Protrusion/Sciatica/Sacroiliac Disorder, [pg * ]
<input type="checkbox"/>	<input type="checkbox"/>	4. Heart/Circulatory/Stroke/Aneurysm/Cholesterol, [pgs *]	<input type="checkbox"/>	<input type="checkbox"/>	13. Arthritis/Rheumatoid Arthritis/Bone/Joint Disorder/Inflammatory Joint Disorder/TMJ, [pgs * ]
<input type="checkbox"/>	<input type="checkbox"/>	5. Respiratory/Lung/Asthma/Allergies/TB/COPD, [pg * ]	<input type="checkbox"/>	<input type="checkbox"/>	14. Muscular Disorder/Lupus/Connective Tissue Disorder/Auto-Immune Disorder, [pg * ]
<input type="checkbox"/>	<input type="checkbox"/>	6. Ears/Eyes/Nose/Throat/Skin Disorder, [pg * ]	<input type="checkbox"/>	<input type="checkbox"/>	15. Cancers/Tumors/Cysts/Neoplasms, [pgs * ]
<input type="checkbox"/>	<input type="checkbox"/>	7. Digestive/Intestinal/Liver Disorder/Acid Reflux/Crohn's/ Polyps/ Hepatitis/Cirrhosis [pgs * ]	<input type="checkbox"/>	<input type="checkbox"/>	16. HIV/AIDS/ARC/Chronic or Infectious Disease, [pg * ]
<input type="checkbox"/>	<input type="checkbox"/>	8. Prostate/Reproductive Organ Disorder/Infertility/STD, [pg * ]	<input type="checkbox"/>	<input type="checkbox"/>	17. Any Other Illness, Disease or Injury, [pg *]
<input type="checkbox"/>	<input type="checkbox"/>	9. Urinary Tract/Kidney or Renal Disease, [pg * ]	<input type="checkbox"/>		

## Statements of Understanding

Please read all statements below.

1. I understand that this is an application only, and I should not cancel any coverage that I currently have until I am notified of acceptance for coverage by Mercy Health Plans (MHP).
2. I understand that I will receive either an acceptance, premium adjustment or denial from MHP, or a letter explaining the reason for the delay, within 60 days of MHP's receipt of this application.].
3. I understand that if the bank returns any payments due to insufficient funds, I will be assessed a fee. Additionally, I understand that if my premiums are not paid within the billing grace period, my coverage will be terminated as to the date when my premiums were paid in full. If my coverage is terminated, I will be unable to reapply for an Individual policy with Mercy Health Plans for one year.
4. I understand that if a Producer (Agent or Broker) is handling my request, the agent is not authorized to waive a complete answer to any question, make a decision as to insurability, make or alter any contract or waive any other rights or requirements of Mercy Health Plans.
5. I understand that if I or any covered family members am/are accepted for medical coverage, any pre-existing medical and/or mental health condition disclosed within this application will not be covered for up to 12 months after my effective date. (Credit may be given for prior creditable coverage upon receipt of certificate of creditable coverage.)
6. I understand that if any pre-existing condition(s) is/are subsequently discovered that were not disclosed during the application process, benefits will be withheld for 12 months for that condition or the coverage may be rescinded in its entirety at MHP's discretion.
7. I understand that I or any of my covered family members may need to obtain a physical examination at my own expense and submit the results as part of my application for coverage, if such an examination has not been performed within the last two years.
8. I understand that I or any of my covered family members have an obligation to notify Mercy Health Plans if we become aware of any medical conditions/injuries/disease states that would cause a reasonably prudent person to seek or require medical attention, from the time this application is signed to before the effective date of coverage. In this situation, MHP has the right to re-underwrite the application using this new information, and the decision to provide coverage may change.
9. I understand and agree that Mercy Health Plans may obtain or request information needed to process this application from me, my physician(s) and medical or pharmaceutical databases. A Mercy Health Plans' employee will then review this information. Any and all additions or corrections will then become part of the application. I understand that Mercy Health Plans will rely on this form and any information received to issue coverage.
10. I understand that if I omit or falsify information in a manner that is considered fraudulent or intentionally misleading, this may result in the cancellation of this coverage based on the terms of the policy. I agree to promptly repay any benefit payment(s) to which my covered family member(s) and/or I were not entitled.
11. I understand and agree that other health insurance coverage that I have might reduce my benefits under this Policy.

**Please note:**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

# Authorization to Use and Disclose Protected Health Information

**NOTE:** It is required that this *Authorization to Use and Disclose Protected Health Information* be completed and submitted with the application. The application is not complete without this authorization form.

**Each person age 18 or over who is to be covered by this policy must sign at the bottom of this form.**

I authorize Mercy Health Plans (MHP) or its affiliates to obtain necessary individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports from physicians, hospitals or other health care providers pertaining to my care or the care of any other dependent(s) listed on the application for insurance. I understand that this information can be used to determine my/our eligibility for insurance, and that those records can be requested as far back as the past ten years.

I authorize MHP to share necessary information with my Producer (Broker or Agent). I understand that Mercy Health Plans may disclose individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports to other entities in the course of its business operations or as required or permitted by law or as set out in the Mercy Health Plans Notice of Privacy Practices and authorize such disclosure. Federal regulations require that we inform you that under certain limited circumstances (e.g., judicial subpoena, state health department, etc.) the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by such regulation.

This authorization is valid for the duration of my coverage with Mercy Health Plans. I understand that this authorization is voluntary and that I may revoke this authorization at any time; however, if I do so before I am enrolled in the policy(ies), my application for coverage may be denied. A revocation request must be sent to MHP in writing to our home address, or via e-mail. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

**All listed applicants 18 years of age and older must agree to the terms of this authorization by signing below.**

**By signing, I agree that I have fully read this entire application, including all seven (7) pages of the Secondary Health Questionnaire, and I understand and agree with all statements contained herein. I also certify that I have answered all questions on the application and Secondary Health Questionnaire completely and accurately. I understand and agree to the release of information for the purpose(s) described above in this document.**

By checking this box ☐ I hereby certify that I have read all seven (7) pages of the Secondary Health Questionnaire and that I have no responses or information to provide to any of the questions presented.

	Signature Required:	Printed Name:	Date:
Applicant	X		
Applicant's Spouse	X		
Dependent 18 yrs. or older	X		
Dependent 18 yrs. or older	X		
Dependent 18 yrs. or older	X		

**If your application is dated more than 60 days before the requested effective date for coverage, a new application may need to be completed.**

**Note: Coverage will not begin until all necessary information is received by MHP. MHP will notify you of the approved effective date.**

**Applicant's Name:** \_\_\_\_\_

## Payment Information

All premium payments are made **either** via debit ACH (automatic withdrawal) [or by] Credit Card payment\* [or by monthly invoice].

**Please check your method of payment:**

<input type="checkbox"/> <b>Monthly Invoice</b> – An invoice will be sent monthly to your home billing address unless a separate billing address is listed below:				
Name _____	Address (street and P.O. Box if applicable) _____	City _____	State _____	Zip _____
<input type="checkbox"/> <b>Automatic Bank Account Withdrawal</b>				
<input type="checkbox"/> Checking account (attach voided check below) <b>Account #</b> _____ <b>Routing #</b> _____ <input type="checkbox"/> My first payment only <input type="checkbox"/> My first and ongoing payments <input type="checkbox"/> My ongoing payments only (first payment made by other method)				
<input type="checkbox"/> Savings Account (attach deposit slip) ) <b>Account #</b> _____ <b>Routing #</b> _____ <input type="checkbox"/> My first payment only <input type="checkbox"/> My first and ongoing payments <input type="checkbox"/> My ongoing payments only (first payment made by other method)				
I authorize Mercy Health Plans (MHP) to draft my Bank Account each month for the amount of my monthly premium. I understand that this authorization is in effect until I notify MHP in writing that I no longer desire these services, allowing them reasonable time to act upon my notification.				
<b>Signature of Account Holder:</b> <b>X</b>		<b>Date:</b> <b>X</b>		
<input type="checkbox"/> <b>Credit Card Payment</b>				
Type of Credit Card:	<input type="checkbox"/> VISA	<input type="checkbox"/> MasterCard	<input type="checkbox"/> American Express	
Credit Card Number: _____	Expiration Date: ____ / ____ (mm/yy)			
Cardholder's Name (as it appears on the card): _____				
Cardholder's Address: _____	_____	City _____	State _____	Zip _____
Telephone: _____				
<input type="checkbox"/> I authorize Mercy Health Plans to charge my credit card each month for the amount of my monthly premium.  <input type="checkbox"/> I authorize a one-time charge to my credit card for \$______ premium [plus a 2% administration fee].				
<b>Signature of Cardholder:</b> <b>X</b>		<b>Date:</b> <b>X</b>		
<input type="checkbox"/> <b>NEW LIST BILL</b> – Billing through a third-party (This option must have prior approval and requires separate List Bill forms to be completed and submitted with this application).  <input type="checkbox"/> <b>CHANGE TO EXISTING LIST BILL</b>				

**Note:** You may be charged an additional fee for insufficient funds or incorrect banking information

**Attach Voided Check Here**

## SECONDARY HEALTH QUESTIONNAIRE

**Note: You must answer each question for yourself and for everyone you are applying for. Answer all categories 'YES' or 'NO'. If you answer 'YES' to a category, make sure to complete the detailed section not only for yourself but for everyone you are applying for.**

Have you/family member ever been diagnosed with, or sought treatment for any of the following conditions?

	YES	NO
<b>1. Diabetes/Sugar in Urine/Abnormal Blood Sugar/Pre-Diabetes/Hypoglycemia</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Diabetes/Pre-diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Which type of diabetes has been diagnosed?		
Type I, Insulin Dependent	<input type="checkbox"/>	<input type="checkbox"/>
If Type I, # units of insulin per day?		
<input type="checkbox"/> < 75 units <input type="checkbox"/> > 100 units		
<input type="checkbox"/> 75-100 units <input type="checkbox"/> Don't know		
Type II, Non-Insulin dependent	<input type="checkbox"/>	<input type="checkbox"/>
Gestational	<input type="checkbox"/>	<input type="checkbox"/>
Date of delivery (in MM/YYYY)	/	/
Other type/Don't know	<input type="checkbox"/>	<input type="checkbox"/>
Date initial diabetes diagnosis made: (MM/YYYY)	/	/
Oral meds to control blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>
Provide recent HbA1c or average glucose levels (within last six months).		
If fasting glucose levels		
<input type="checkbox"/> 65-115 <input type="checkbox"/> 116-175 <input type="checkbox"/> >175		
If random glucose levels		
<input type="checkbox"/> <200 <input type="checkbox"/> 201-250 <input type="checkbox"/> >250		
If HbA1c level		
In addition, do you/family member have any of these conditions?		
Diabetic eye complications	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems/Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
<b>2. Endocrine System/Thyroid/Pituitary/Adrenal</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Hyperthyroidism/Hashimoto's Thyroiditis/Graves Disease/Excess thyroid hormone	<input type="checkbox"/>	<input type="checkbox"/>
What kind of treatments have you/family member had for this?		
<input type="checkbox"/> Surgery <input type="checkbox"/> Radioactive Iodine <input type="checkbox"/> Other		
If surgery, date of surgery: (MM/YYYY)	/	/
If surgery not done, does RX control disease?	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism-low thyroid hormone	<input type="checkbox"/>	<input type="checkbox"/>
Toxic Thyroid Goiter-Plummer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
When was diagnosis made (in MM/YYYY)?	/	/
Hyperparathyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Did you/family member have surgery for?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, does medication control disease?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	/	/
Hyperaldosteronism (Cushing's disease)	<input type="checkbox"/>	<input type="checkbox"/>
Is the cause of disease known?	<input type="checkbox"/>	<input type="checkbox"/>
If cause is known, describe condition:		
Date condition diagnosed: (in MM/YYYY)	/	/
Is the condition stable with treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Addison's Disease (Chronic Adrenal Insufficiency)	<input type="checkbox"/>	<input type="checkbox"/>

Growth Hormone Deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Other Thyroid/Endocrine system disorder	<input type="checkbox"/>	<input type="checkbox"/>
Please describe:		

	YES	NO
<b>3. High Blood Pressure/Hypertension</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

THREE recent blood pressure readings in systolic/diastolic format

Systolic	Diastolic	Date Taken

Readings taken while on meds for hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
Diagnosed with malignant hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
Has the diagnosis of hypertension required:		
An ER visit?	<input type="checkbox"/>	<input type="checkbox"/>
A hospital stay?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
<b>4. Heart/Circulatory/Stroke/Aneurysm/Cholesterol</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Which type of aneurysm?		
<input type="checkbox"/> Abdominal/Descending Thoracic Aortic <input type="checkbox"/> Brain		
<input type="checkbox"/> Femoral/Peripheral <input type="checkbox"/> Other type		
Has aneurysm been operated on?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	/	/
If NO, any further problems?	<input type="checkbox"/>	<input type="checkbox"/>
Hypercholesterolemia/Hyperlipidemia/High blood lipids/High blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
What are cholesterol levels (in mg/dl)?		
<input type="checkbox"/> <=220 <input type="checkbox"/> >220<=250		
<input type="checkbox"/> >250<=300 <input type="checkbox"/> >300		
Are above levels while on cholesterol meds?	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
What type of anemia do you/family member have?		
<input type="checkbox"/> Unknown/Other <input type="checkbox"/> Thalassemia Major		
<input type="checkbox"/> Pernicious <input type="checkbox"/> Iron Deficiency		
<input type="checkbox"/> Sickle Cell <input type="checkbox"/> Hemolytic Anemia		
If hemolytic, have you/family member had a splenectomy?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	/	/
Bleeding disorders/Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease/Heart Attack/Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had?		
<input type="checkbox"/> Angioplasty/Balloon/Stent Procedure - How many? _____		
<input type="checkbox"/> Cardiac Bypass Surgery		
<input type="checkbox"/> Neither Angioplasty nor Bypass Surgery		
If performed, date procedure done: (MM/YYYY)	/	/

If history of heart attacks, give date: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Congestive Heart Failure ☐ ☐

Is the only treatment drug therapy? ☐ ☐

Have you/family member had any hospitalizations for? ☐ ☐

Cardiomegaly/Enlarged heart ☐ ☐

Are you/family member a heart transplant candidate? ☐ ☐

Is the reason for the enlargement known? ☐ ☐

If known, describe: \_\_\_\_\_

---

Do you/family member have any impairment from condition? ☐ ☐

Peripheral Vascular Disease/Claudication ☐ ☐

Is diagnosis? ☐ Reynaud's Disease ☐ Buerger's Disease ☐ Neither Reynaud's or Buerger's

Cerebral Vascular Accident (CVA)/Stroke/Transient Ischemic Attack (TIA)/Small Stroke ☐ ☐

Was diagnosis CVA or TIA? ☐ CVA ☐ TIA

Date symptoms began: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Any residual impairment? ☐ ☐

Arrhythmias/Atrial Fibrillation/Rhythm Problem ☐ ☐

Episodes are: ☐ Single ☐ Multiple ☐ Chronic

If multiple, are they controlled? ☐ ☐

If YES, are they controlled by? ☐ Drugs ☐ Surgical device

Conduction disturbances/Bundle Branch Blocks ☐ ☐

Cause known for conduction disturbances? ☐ ☐

If cause known, describe: \_\_\_\_\_

---

Cardiac implantable device/pacemaker installed? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Chest pain/Angina/Ischemic Heart Disease ☐ ☐

Is clinical work up suggestive of coronary artery disease/blocked cardiac arteries? ☐ ☐

If NO, date of symptoms onset: (in MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Deep Vein Thrombosis/Blood Clots in Legs/Phlebitis ☐ ☐

Do you/family member currently have one of these conditions? ☐ ☐

Have you/family member had? ☐ Single episode ☐ Multiple episodes

If single episode, date of onset of symptoms: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

If multiple, date recovered from last episode: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Are you/family member on anti-clotting RX? ☐ ☐

Edema/Swelling of the extremities ☐ ☐

Do you/family member know what is causing swelling? ☐ ☐

If YES, describe: \_\_\_\_\_

---

Cardiac Valve disorders/Heart Murmur/Valve Prolapse/Regurgitation/Stenosis of Valve ☐ ☐

Have you/family member had surgery for condition? ☐ ☐

If YES, was the valve: ☐ Repaired ☐ Replaced

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

If NO, are you/family member symptomatic? ☐ ☐

Carotid Artery Occlusion ☐ ☐

Is disease symptomatic and documented? ☐ ☐

Have you/family member had surgery to correct? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Cardiomyopathy ☐ ☐

Are you/family member on the waiting list for heart transplant? ☐ ☐

Do you/family member know what is causing cardiomyopathy? ☐ ☐

If YES, describe: \_\_\_\_\_

Pericarditis ☐ ☐

Did you/family member have surgery? ☐ ☐

If surgery, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Other disease of the heart or circulatory system ☐ ☐

Please describe: \_\_\_\_\_

	YES	NO
<b>5. Respiratory/Lung Disorder/Asthma/TB/COPD</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: \_\_\_\_\_

Allergies/Asthma ☐ ☐

Do you/family member have? ☐ Asthma & Allergies ☐ Allergies Only ☐ Asthma Only

If allergies, are you/family member on desensitization shots? ☐ ☐

If asthma, are attacks occasional or frequent? ☐ Occasional ☐ Frequent

If asthma, any hospitalizations for? ☐ ☐

If asthma, nebulizer used for acute episodes? ☐ ☐

If asthma, are you/family member taking corticosteroids? ☐ ☐

Is asthma under control with medications? ☐ ☐

Chronic Obstructive Lung Disease (COPD) or Emphysema ☐ ☐

Sleep Apnea ☐ ☐

If YES, do you/family member have a C-Pap machine? ☐ ☐

If NO, has it been recommended by a health care provider that you/family member get a C-Pap machine? ☐ ☐

Have you/family member had surgery for? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Bronchitis ☐ ☐

In last two years number of hospitalizations for bronchitis? ☐ Not at all ☐ One time ☐ > Than once

Pulmonary Embolism/Pulmonary Infarction ☐ ☐

Is it known what caused embolism/infarction? ☐ ☐

Please describe: \_\_\_\_\_

---

Single episode of symptoms? ☐ ☐

Are you/family member continuing anticoagulant drug treatment? ☐ ☐

Have you/family member fully recovered? ☐ ☐

Dyspnea/Shortness of Breath ☐ ☐

Known underlying condition causing this? ☐ ☐

Please describe underlying condition: \_\_\_\_\_

---

Is the shortness of breath exercise induced? ☐ ☐

How would you/family member characterize symptoms? ☐ Mild ☐ Moderate ☐ Severe

Pulmonary Hypertension ☐ ☐

Are you/family member a recipient/candidate for a lung transplant? ☐ ☐

Other respiratory condition ☐ ☐

Please describe: \_\_\_\_\_

	YES	NO
<b>6. Ear/Eye/Nose/Throat/Skin Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Middle ear infections/tubes in ears/Otitis Media ☐ ☐

Are infections chronic? ☐ ☐

Has there been more than one infection? ☐ ☐

Are tubes present in ear canals? ☐ ☐

Date of most recent episode: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Any hearing impairment? ☐ ☐

If YES, does it require a hearing aid? ☐ ☐

If YES, do you/family member need a cochlear implant? ☐ ☐

Cataracts ☐ ☐

Both eyes? ☐ ☐

Have you/family member had surgery on? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Glaucoma ☐ ☐

If YES, provide current ocular pressure: \_\_\_\_\_

Tonsillitis ☐ ☐

Have you/family member had surgery for? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Single episode of symptoms? ☐ ☐

Date of last episode of symptoms: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Psoriasis/Chronic Skin Condition/Eczema ☐ ☐

Episodes are: ☐ Mild ☐ Moderate ☐ Severe

Taking Enbrel/Other Biologic RX injections for? ☐ ☐

Acne ☐ ☐

Cellulitis-skin infection ☐ ☐

More than one episode? ☐ ☐

Are the episodes severe? ☐ ☐

When was since last episode? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Sinusitis/Sinus Infection ☐ ☐

Is condition chronic? ☐ ☐

How many infections do you/family member have a year? \_\_\_\_\_

Other Ear/Eye/Nose/Throat or Skin condition ☐ ☐

Please describe: \_\_\_\_\_

	YES	NO
<b>7. Digestive/Intestinal/Liver Disorder/Acid Reflux/Crohn's/Polyps/Hepatitis/Cirrhosis</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

GERD/Gastroesophageal Reflux Disease/Acid Reflux ☐ ☐

Did symptoms abate/improve with drug therapy? ☐ ☐

Are drugs you/family member taking prescribed by physician? ☐ ☐

Ulcers/Peptic Ulcers/Duodenal Ulcers/Gastric Ulcers ☐ ☐

Have you/family member had surgery for condition? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Crohn's Disease/Inflammatory Bowel Disease ☐ ☐

Have you/family member had surgery for condition? ☐ ☐

If YES, what kind of surgery was done? ☐ Partial bowel resection ☐ Total bowel resection

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Colitis/Irritable Bowel Syndrome (IBS)/Spastic Colitis ☐ ☐

☐ Currently under treatment

☐ Single Attack in the past

☐ Multiple Attacks in the past

If multiple date of last episode of symptoms: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Gastrointestinal Bleeding ☐ ☐

When was last bleeding episode? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Are you/family member currently under treatment? ☐ ☐

Cirrhosis of the Liver/Hepatitis/Liver Disease ☐ ☐

Which type of liver disease has been diagnosed?

☐ Cirrhosis ☐ Hepatitis C

☐ Hepatitis A ☐ Alcoholic Hepatitis

☐ Hepatitis B ☐ Chronic Hepatitis

If Hepatitis A, B or C - Normal liver function tests? ☐ ☐

If Hepatitis C - Taking Interferon by injection? ☐ ☐

Gall Bladder Disease/Cholelithiasis/Cholecystitis ☐ ☐

Was it a single attack of symptoms? ☐ ☐

Has the gall bladder been removed? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

If NO, date of last attack of symptoms? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Fatty Liver (NASH) ☐ ☐

Ulcerative Colitis/Chronic Inflammation of Colon ☐ ☐

Single or multiple episodes? ☐ ☐

Have you/family member had surgery for condition? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

If YES, are you/family member on prescription medications? ☐ ☐

If NO, is condition under control? ☐ ☐

If NO, are you/family member taking steroid medication? ☐ ☐

If NO, date last episode of symptoms: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Diverticulitis/Diverticulosis ☐ ☐

Do you/family member currently have symptoms from this? ☐ ☐

Have you/family member had surgery for? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Colon Polyps/Rectal Polyps ☐ ☐

Benign? ☐ ☐

Have you/family member had surgery on? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Hernia ☐ ☐

If YES, what kind of hernia?

☐ Inguinal ☐ Femoral

☐ Scrotal ☐ Ventral

Has it been operated on? ☐ ☐

If no, any symptoms from? ☐ ☐

If no operation and symptomatic, are symptoms managed by medicine? ☐ ☐

Pancreatitis ☐ ☐

**YES** **NO**

Is condition chronic or acute? ☐ ☐

Any history of alcohol use? ☐ ☐

Any subsequent liver disease? ☐ ☐

Single episode of pancreatitis? ☐ ☐

Do you/family member currently have this condition? ☐ ☐

If NO, date of last episode of symptoms: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Other digestive/intestinal disorder ☐ ☐  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_

	YES	NO
<b>8. Prostate/Reproductive Organ Disorder/Infertility/ STD</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Uterine fibroids/Dysfunctional Uterine Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had a hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	
Was there a malignancy?	<input type="checkbox"/>	<input type="checkbox"/>
Benign Prostatic Hypertrophy/Prostatic Enlargement	<input type="checkbox"/>	<input type="checkbox"/>
Is there a malignancy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had prostate surgery?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	
Any symptoms or voiding difficulties related to prostatic enlargement?	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
Which type?		
<input type="checkbox"/> Genital Herpes-Date of last episode: (MM/YYYY)	____/____/____	
<input type="checkbox"/> Chlamydia - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gonorrhea - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Syphilis - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Venereal Warts - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>
If YES, are you/family member on infertility treatments?	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>
Are the cysts benign?	<input type="checkbox"/>	<input type="checkbox"/>
Any symptoms from condition?	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Dysplasia/Abnormal Pap Smears	<input type="checkbox"/>	<input type="checkbox"/>
More than one abnormal Pap in the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
Prolapsed Uterus	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery to correct?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	
Do you/family member have a history of complications of pregnancies or deliveries?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had an infant that was premature?	<input type="checkbox"/>	<input type="checkbox"/>
With congenital abnormalities/anomalies/defects?	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		
Other disorder/abnormality of the reproductive system	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

	YES	NO
<b>9. Urinary Tract/Kidney or Renal Disease</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Cystitis/Urinary Tract Infection (UTI)/Pyuria/Urethritis	<input type="checkbox"/>	<input type="checkbox"/>
Single episode?	<input type="checkbox"/>	<input type="checkbox"/>
When was last episode (in MM/YYYY)?	____/____/____	
Was there any protein/discharge/blood in urine?	<input type="checkbox"/>	<input type="checkbox"/>
Cystic disease of kidneys	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Solitary Cyst <input type="checkbox"/> Polycystic		
Have you/family member had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	

Have you or any family member applying for coverage had a kidney transplant ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Any post-surgical complications? ☐ ☐  
 Renal calculi/Kidney stones ☐ ☐  
 Currently have? ☐ ☐  
 If NO, date of last episode: (MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 More than two episodes of symptoms? ☐ ☐  
 Were stones in one or both kidneys? ☐ ☐  
☐ Unilateral/One kidney only  
☐ Bilateral/Both kidneys  
 Interstitial cystitis ☐ ☐  
 Currently have? ☐ ☐  
 If NO, date of last episode: (MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Acute Renal failure/Chronic Renal failure ☐ ☐  
 Currently have? ☐ ☐  
 If NO, date of recovery: (MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Urinary Incontinence ☐ ☐  
 Other Kidney/Urinary tract disorder ☐ ☐  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_

	YES	NO
<b>10. Nervous System/Brain Disorder/Headache/ Epilepsy/Seizure Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Headaches/Migraines/Cluster Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Situational Headaches (menstrual, stress, other)?	<input type="checkbox"/>	<input type="checkbox"/>
Characterization of severity & frequency of headaches (Pick one):		
<input type="checkbox"/> Mild and/or less than 5/year <input type="checkbox"/> Severe and/or > 10/year		
<input type="checkbox"/> Moderate and/or 5 - 10/year <input type="checkbox"/> Onset less than 6 months		
Head Injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Was there a loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, how long was loss of consciousness?	____/____/____	
<input type="checkbox"/> < 1 hour <input type="checkbox"/> < 1 day <input type="checkbox"/> More than 1 day		
If < 1 hour, any residual problems post recovery?	<input type="checkbox"/>	<input type="checkbox"/>
If < 1 day, give date of recovery: (MM/YYYY)	____/____/____	
If < 1 day, any residual problems post recovery?	<input type="checkbox"/>	<input type="checkbox"/>
Encephalitis/Encephalomyelitis	<input type="checkbox"/>	<input type="checkbox"/>
Currently have?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, any residual complications post recovery?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, how long since recovery (in MM/YYYY)?	____/____/____	
Neuroma/Abnormal Nerve Growth	<input type="checkbox"/>	<input type="checkbox"/>
Is growth benign?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member been operated on?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, when was surgery (MM/YYYY)?	____/____/____	
If NO, when was recovery (MM/YYYY)?	____/____/____	
Is the diagnosis Morton's Neuroma?	<input type="checkbox"/>	<input type="checkbox"/>
Amyotrophic Lateral Sclerosis (ALS)/Lou Gehrig's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Reflex Sympathetic Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
If YES, have currently or recovered from?		
<input type="checkbox"/> Current <input type="checkbox"/> Recovered from		
If recovered, date of recovery: (MM/YYYY)	____/____/____	
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
If YES, have currently or recovered from?		
<input type="checkbox"/> Currently have <input type="checkbox"/> Recovered from		
If recovered, date of recovery: (MM/YYYY)	____/____/____	

Peripheral Neuropathy ☐ ☐  
 Is another disease condition causing neuropathy? ☐ ☐  
 If YES, please describe: \_\_\_\_\_

Epilepsy/Seizure Disorder ☐ ☐  
 Do you/family member know what type of seizure has been diagnosed? ☐ ☐  
 If YES, what is seizure type?  
☐ Febrile ☐ Petit Mal ☐ Jacksonian  
☐ Grand Mal ☐ Focal  
 Is another disease condition causing seizures? ☐ ☐  
 If YES, please describe: \_\_\_\_\_

Heat Exhaustion/Heat Stroke ☐ ☐  
 Which diagnosis? ☐ Heat Exhaustion ☐ Heat Stroke  
 Single episode? ☐ ☐  
 If NO, date of last episode: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Autism ☐ ☐  
 Cerebral Palsy ☐ ☐  
 Paralysis/Hemiplegia/Paraplegia ☐ ☐  
 Parkinson's Disease ☐ ☐  
 Spina Bifida ☐ ☐  
 Viral Meningitis ☐ ☐  
 Bacterial Meningitis ☐ ☐  
 Muscular Dystrophy ☐ ☐  
 Multiple Sclerosis ☐ ☐  
 Motor Neuron Disease ☐ ☐  
 Neuralgia/Neuritis ☐ ☐  
 Dementia ☐ ☐  
 Other disorder of the nervous system ☐ ☐  
 Please describe: \_\_\_\_\_

	YES	NO
<b>11. Mental or Psychiatric Condition/Depression/Behavioral (e.g., Attention-Deficit Hyperactivity Disorder) or Eating Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: \_\_\_\_\_

Affective Disorders ☐ ☐  
 What is diagnosis (pick one below)?  
☐ Obsessive Compulsive Disorder (OCD)  
☐ Panic Disorder ☐ Agoraphobia  
☐ Anxiety Disorder ☐ Neuroses

Is treatment effective? ☐ ☐  
 If YES, date treatment became effective? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

What is characterization of severity of symptoms?  
☐ Mild ☐ Moderate ☐ Severe

Schizophrenia/Paranoia ☐ ☐  
 Eating Disorder/Bulimia/Anorexia ☐ ☐

Do you/family member currently have an eating disorder? ☐ ☐  
 When was recovery? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Attention Deficit Disorder/ADD/ADHD ☐ ☐

	YES	NO
What is characterization of severity of symptoms?		
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Are symptoms controlled by medication?	<input type="checkbox"/>	<input type="checkbox"/>

Situational Depression/Mild Depression/Anxiety ☐ ☐  
 Is only current treatment prescription medication? ☐ ☐

Major Depression/Bipolar Disorder ☐ ☐  
 When was diagnosis made? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Have you/family member ever sought, or are you seeking professional counseling/therapy for a mental health issue? ☐ ☐

Date of last treatment? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Other mental health/psychiatric disorder ☐ ☐

Please describe: \_\_\_\_\_

	YES	NO
<b>12. Back or Neck Disorder/Lumbago/Disc Herniation or Protrusion/Sciatica/Sacroiliac Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: \_\_\_\_\_

Cervical (Neck) or Thoracic (Mid Back) or Lumbar (Low Back) Disc Herniation or Protrusion ☐ ☐

Are you/family member under current treatment for? ☐ ☐

Have you/family member had surgery for condition? ☐ ☐

If YES, any subsequent problems post-op? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

If no surgery was done, have you/family member recovered? ☐ ☐

If you/family member have recovered, date of Recovery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Low Back Pain/Lumbago/SI Joint/Sciatica ☐ ☐

Are you/family member under current treatment for? ☐ ☐

If not in current treatment, date of last episode: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Spinal Fractures ☐ ☐

Any lingering neurological defects? ☐ ☐

Was fracture a compression fracture? ☐ ☐

When was last treatment (in MM/YYYY)? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Spinal Stenosis ☐ ☐

Have you/family member had surgery for condition? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Low Back Strain/Whiplash/Muscle Spasm ☐ ☐

Are you/family member under current treatment for? ☐ ☐

Ankylosing Spondylitis/Spondylolisthesis ☐ ☐

Have you/family member had surgery for condition? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

If NO, is condition symptomatic/requiring treatment? ☐ ☐

Sciatica/Radiculitis/Radiating pain to legs or arms ☐ ☐

Do you/family member have any neurological defects? ☐ ☐

Are you/family member currently under treatment for? ☐ ☐

Are episodes recurrent? ☐ ☐

When was last episode (in MM/YYYY)? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Spinal deformities/Scoliosis/Lordosis ☐ ☐

Have you/family member had surgery for condition? ☐ ☐

If surgery, any continuing problems post-op? ☐ ☐

If surgery was done, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

If no surgery, are you/family member currently under treatment? ☐ ☐

If you/family member are currently under treatment, is condition?

☐ Mild ☐ Moderate ☐ Severe

If no current treatment, date of last treatment? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Spina Bifida/Myelocele ☐ ☐  
 Have you/family member had surgery for condition? ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 If YES, any residual neurological defects? ☐ ☐  
 Other back/neck disorder ☐ ☐  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**13. Arthritis/Rheumatoid Arthritis/Bone/Joint Disorder/Inflammatory Joint Disease/TMJ**

YES NO

If YES, list family member(s) affected: \_\_\_\_\_

Arthritis ☐ ☐  
 Kinds of arthritis do you/family member have?  
☐ Degenerative ☐ Chronic proliferative  
☐ Hypertrophic ☐ Arthritis deformans  
☐ Senile ☐ Psoriatic  
☐ Juvenile Rheumatoid ☐ Chondrocalcinosis  
☐ Adult Rheumatoid ☐ Septic  
☐ Atrophic ☐ Acute Infectious  
☐ Osteoarthritis  
 Is condition asymptomatic? ☐ ☐  
 If symptomatic, date of first onset of symptoms: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Is more than one joint affected? ☐ ☐  
 If no, is the joint a hip or knee? ☐ ☐  
 Have you/family member had a hip/knee replacement? ☐ ☐  
 If you/family member had surgery, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Characterization of disease progression/degree of disability:  
☐ Mild, Minimal ☐ Moderate to Severe  
 Is there a joint infection? ☐ ☐  
 Osteomyelitis/Bone Infection/Bone Abscess ☐ ☐  
 Was there only a single episode? ☐ ☐  
 Involved joint/bone was:  
☐ Major joint/bone ☐ Minor joint/bone  
 TMJ Disorder/Disease ☐ ☐  
 TMJ Syndrome/Jaw Pain ☐ ☐  
 Under current treatment for? ☐ ☐  
 If NO, date treatment completed: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Bursitis/Tennis Elbow/Tendonitis/Synovitis ☐ ☐  
 Was there only a single episode of symptoms? ☐ ☐  
 Under current treatment for? ☐ ☐  
 Osteoporosis ☐ ☐  
 Is underlying cause known for condition? ☐ ☐  
 If YES, please describe cause for condition below:  
 \_\_\_\_\_  
 Any symptoms from? ☐ ☐  
 Any subsequent fractures? ☐ ☐  
 Do you/family member take steroids for condition? ☐ ☐  
 Carpal Tunnel Syndrome ☐ ☐  
 Have you/family member had surgery for? ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Ligament tears/Torn Meniscus/Osteochondritis/Dessicans/Chondromalacia ☐ ☐  
 Have you/family member had surgery for? ☐ ☐  
 If surgery, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Bone dislocation ☐ ☐  
 Was the dislocation (choose one, below)?  
☐ Congenital hip ☐ Patella (kneecap)  
☐ Shoulder ☐ Knee (not kneecap)  
☐ Hip-traumatic ☐ Other joint-traumatic  
 Was there a single episode of symptoms? ☐ ☐  
 Do you/family member currently have? ☐ ☐  
 Have you/family member had surgery on? ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Dislocation was:  
☐ Unilateral/one sided ☐ Bilateral/both sides  
 Bone fracture ☐ ☐  
 Has treatment been completed? ☐ ☐  
 Have you/family member had surgery on? ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Was the fracture? ☐ Union ☐ Non-Union  
 Was the fracture of?  
☐ Leg/hip/foot  
☐ Arm/hand/shoulder  
☐ Other bone  
 Foot pain ☐ ☐  
 Bunions ☐ ☐  
 If YES, have you/family member had surgery for? ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Plantar fasciitis ☐ ☐  
 Rotator cuff tear ☐ ☐  
 Have you/family member had surgery on? ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Date of original injury: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Gout/Gouty Arthritis/Hyperuricemia ☐ ☐  
 Characterization of number of attacks:  
☐ Few ☐ Frequent  
 Are attacks well controlled by medication/diet? ☐ ☐  
 Other bone/joint disorder ☐ ☐  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**14. Muscular Disorder/Lupus/Connective Tissue/Autoimmune Disorder**

YES NO

If YES, list family member(s) affected: \_\_\_\_\_

Collagen diseases:Scleroderma/Ehlers-Danlos Syndrome/Mixed Connective Tissue disease/Necrotizing Angiitis ☐ ☐  
 Lupus Erythematosus ☐ ☐  
 Fibromyalgia/Myitis/Myositis ☐ ☐  
 Currently being treated? ☐ ☐  
 If no current treatment, date of recovery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Recurrent episodes? ☐ ☐  
 Polymyositis/Neuromyositis/Dermatomyositis ☐ ☐  
 Autoimmune Disorder/Disease ☐ ☐  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 Ligament tears/Meniscus tears/Osteochondritis/Dessicans/Chondromalacia ☐ ☐  
 Have you/family member had surgery for condition? ☐ ☐  
 If surgery, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Other Muscle/Connective Tissue/Autoimmune disorder ☐ ☐  
Please describe: \_\_\_\_\_

**15. Cancer/Tumors/Cysts/Neoplasm**

YES NO  
☐ ☐

If YES, list family member(s) affected:

Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Basal Cell/Squamous Cell Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Lipoma/Adipose Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Colon/Rectal Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Other kind of cancer	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

Are you/family member under current treatment? ☐ ☐

If NO, date treatment completed: (MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

What was stage of the tumor?

☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

When diagnosed? (in MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

Was the treatment surgery alone? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

If not, what were the other treatments? ☐ ☐

Please describe: \_\_\_\_\_

Is cancer in remission? ☐ ☐

Is the cancer metastatic? ☐ ☐

Is the cancer recurrent? ☐ ☐

Have you/family member been told you have an abnormal, suspicious lesion/possible pre-malignant condition? ☐ ☐

Has the lesion been removed? ☐ ☐

Cyst ☐ ☐

Please describe: \_\_\_\_\_

Has the cyst been removed? ☐ ☐

YES NO

**16. HIV/AIDS/ARC Chronic or Infectious Disease**

☐ ☐

Have you or any family member applying for coverage been positively diagnosed or treated for HIV/AIDS/ARC Chronic or infectious Disease?

If YES, list family member(s) affected:

HIV (human immunovirus)	<input type="checkbox"/>	<input type="checkbox"/>
AIDS (Acquired Immune Deficiency Syndrome)	<input type="checkbox"/>	<input type="checkbox"/>
ARC (AIDS related complex)	<input type="checkbox"/>	<input type="checkbox"/>
Other chronic or Infectious disease	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

YES NO

**17. Any other Illness, Disease, Condition or Injury**

☐ ☐

If YES, list family member(s) affected:

As a result of an injury or illness have you/family member had any of the treatments listed below?

Bone or skin graft(s) ☐ ☐

Joint replacement ☐ ☐

Loss of limb ☐ ☐

Loss or surgical removal of organ ☐ ☐

If YES, please describe: \_\_\_\_\_

Other Disease/Disease Condition/Disorder/Injury not previously described ☐ ☐

Please describe: \_\_\_\_\_

Date of last treatment (in MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

Treating Physician: \_\_\_\_\_



## BIRTH CONTROL SERVICES ADDENDUM

This Addendum amends the Individual Comprehensive Health Insurance Policy and all the relevant Schedules and Addendums attached thereto (collectively the "Policy") and, unless expressly stated in this Addendum, is subject to all the provisions, exclusions and limitations set forth in the Policy.

Any exclusion(s) related to services specifically covered under this Addendum is hereby deleted in its entirety.

### Covered Services

The Member is entitled to the following temporary forms of prescribed birth controls set forth below:

- Insertion and removal of implantable contraceptive devices (but not more often than once every three (3) [Calendar][Plan][Rolling] Years][thirty-six (36) consecutive months], unless Medically Necessary)
- Insertion and removal of intrauterine device (IUD)
- Administration of contraceptive injections
- Diaphragms

These services are only covered under Mercy Health Plans' pharmacy benefit:

- Oral Contraceptives
- Topical contraceptives
- Contraceptive injections

A handwritten signature in black ink, reading "Charles S. Gilham".

Charles S. Gilham, Vice President  
Mercy Health Plans

### Note

The Covered Person shall be required to pay the same Copayment or Deductible and Coinsurance with respect to the health services described in this Addendum as such Covered Person would be required to pay if the service were Medically Necessary and performed for the treatment of an Illness or Injury, including (but not limited to) the Copayment or Deductible and Coinsurance generally applicable to prescriptions and office visits.

[The Coinsurance for medical services described in this Addendum shall be counted against the applicable Out-of-Pocket Maximum as set forth in the Schedule Coverage and Benefits.

Deductibles do not apply to your Out-of-Pocket Maximum as set forth in the Policy. Charges that apply to the medical Deductible do not apply to any applicable pharmacy deductible.]

[Only] [Deductibles,] [and] [Coinsurances][and Copayments] for Covered Services (medical and pharmacy) described in this Addendum will count towards your Out-of-Pocket Maximum.]

### Exclusions

Under no circumstances will coverage be provided for:

- Sterilization or the reversal of any sterilization procedure.
- Medications or chemicals for which the primary purpose is the induction of an abortion.



## FAMILY SERVICES RIDER

This Rider amends the Comprehensive Individual Health Insurance Coverage Policy and all the relevant Schedules and Riders attached thereto (collectively the "Policy") and, unless expressly stated in this Rider, is subject to all the provisions, exclusions and limitations set forth in the Policy.

Any exclusion(s) related to services specifically covered under this Rider is hereby deleted in its entirety.

### **Covered Services.**

Tubal ligations and vasectomies shall be covered under this Rider.

### **Copayments.**

The Covered Person shall be required to pay the same Copayment/Coinsurance with respect to

the health services described in this Rider as such Covered Person would be required to pay if the service were Medically Necessary and performed for the treatment of an illness or injury, including but not limited to the Copayments/Coinsurance generally applicable to Inpatient Hospital Stay, Outpatient Surgery, and Physician's Office Services. Copayments / Coinsurance paid by a Covered Person for services covered under this Rider shall not be counted for purposes of the applicable annual maximum, which applies to covered services and is set forth in the Policy.

### **Exclusions**

The reversal of any sterilization procedure is not a Covered Service.

A handwritten signature in black ink, reading "Charles S. Gilham".

Charles S. Gilham, Vice President  
Mercy Health Plans



## CRANIOMANDIBULAR AND TEMPOROMANDIBULAR JOINT DISORDER (TMJ) RIDER

This Rider amends the Individual Comprehensive Health Insurance Policy and all the relevant Schedules and Riders attached thereto (collectively the "Policy"), and unless otherwise expressly stated in this Rider is subject to all provisions, exclusions and limitations set forth in the Policy.

For purposes of this Rider, capitalized terms shall have the meaning assigned to them in the Policy.

Except as modified or superseded by the coverage provided under this Rider, all other terms, conditions and exclusions in the Policy remain unchanged and in full force and effect.

### Covered Services

Coverage for the medically necessary treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including the diagnosis and treatment of temporomandibular joint disorders (TMJ) and craniomandibular disorder. Treatment shall include surgical and non-surgical procedures for medically necessary diagnosis and treatment, whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

### Note

The Covered Person shall be required to pay the same Copayment, Deductible and Coinsurance with respect to the health services described in this Rider as such Covered Person would be required to pay if the service were Medically Necessary and performed for the treatment of an

Illness or Injury, including (but not limited to) the cost-sharing generally applicable to inpatient hospital and outpatient hospital services and office visits. [Coinsurances described in this Rider shall not be counted against the applicable Out-of-Pocket Maximum, as set forth in the Schedule Coverage and Benefits. Deductibles do not apply to your Out-of-Pocket Maximum as set forth in the Policy.]. [Only] [Deductibles,] [and] [Coinsurances][and Copayments] for Covered Services described in this Rider will count towards your Out-of-Pocket Maximum.]

### Prior Authorization Required:

Unless We pre-approve these services, Network and Non-Network Benefits will be reduced by 100% of Eligible Expenses.

### Exclusions

Under no circumstances will coverage be provided for:

1. Services for care of teeth including routine preventive care services that would normally be covered under a dental plan, including but not limited to periodic oral exams, periapical or bitewing x-rays, and cleanings/prophylaxis.
2. Services beyond the scope of the Physician's license to practice oral surgery.
3. Services, including consultations that have not received Prior-Authorization.

A handwritten signature in black ink, appearing to read "Charles S. Gilham".

Charles S. Gilham, Vice-President  
Mercy Health Plans



## OUTPATIENT PRESCRIPTION DRUG ADDENDUM

This addendum amends the Individual Comprehensive Health Insurance Policy and the Schedule of Coverage and Benefits attached thereto (collectively, the "Policy"), and unless otherwise expressly stated in this addendum, is subject to all provisions, exclusions, and limitations set forth in the Policy.

This addendum is issued to the enrolling individual and provides Benefits for Outpatient Prescription Drugs. Benefits are greater if received at a Participating Pharmacy. Any applicable Deductible, Coinsurance and/or Copayment will not count towards any applicable Out-of-Pocket Maximum as set forth in the Schedule of Coverage and Benefits. Your Annual Deductible as indicated on the Schedule of Coverage and Benefits must be satisfied before Benefits are payable under this Rider

When We use the words "We", "Us", and "Our" in this document, We are referring to Mercy Health Plans. When We use the words "You" and "Your" We are referring to Covered Persons as defined in the Policy. Unless defined differently in this addendum, all other capitalized terms shall have the meanings given them in the Policy.

### I. GLOSSARY OF TERMS

This section:

- Defines the terms used throughout this addendum.
- Is not intended to describe Benefits.

**Brand-name** – a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that We identify as a Brand-name drug. We classify a Prescription Drug as Brand or Generic based on data provided to Our prescription claims processor by First DataBank or Medi-Span. First DataBank or Medi-Span will periodically change the classification of a drug based on many elements. Upon notification of a

change in classification, the formulary list at [www.mercyhealthplans.com](http://www.mercyhealthplans.com) will be updated. You may also obtain this information by calling Our Customer Contact Center telephone number on the back of Your identification card. A change in classification may affect Your applicable Copayment/Coinsurance for that drug.

**Calendar Year** – the period of twelve (12) months commencing on January 1<sup>st</sup> and each twelve (12) month period thereafter (or other period as indicated in Your Policy), unless otherwise terminated as provided herein.

**Copayment/Coinsurance** – the fee, as set forth in the Schedule of Coverage and Benefits, to be paid directly by Covered Persons, for a Prescription Order or Refill.

**Formulary** – a list of Prescription Drugs that are approved by the Plan for coverage and are dispensed to Covered Persons. The Formulary is subject to periodic review and modification by the Plan without the consent of the Covered Person. Prescription Drugs are given a status of Tier One (or "First Tier"), Tier Two (or "Second Tier"), Tier Three (or "Third Tier"), Tier Four (or "Fourth Tier"), or Not Covered by the Plan's Formulary Management Committee.

**Generic** – a Prescription Drug: (1) that is chemically equivalent to a Brand-name drug; or (2) that We identify as a Generic product. Classification of a Prescription Drug as a Generic is determined by Us and not by the manufacturer or pharmacy. We classify a Prescription Drug as Generic based on data provided to Our prescription claims processor by First DataBank or Medi-Span. Therefore, all products identified as a "generic" by the manufacturer or pharmacy may not be classified as a Generic by First DataBank or Medi-Span. First DataBank or Medi-Span will periodically change the classification of a drug based on many elements.

Upon notification of a change in classification, the formulary list at [www.mercyhealthplans.com](http://www.mercyhealthplans.com) will be updated. You may also obtain this information by calling Our Customer Contact Center telephone number on the back of Your identification card. A change in classification may affect Your applicable Copayment/Coinsurance for that drug.

**Maximum Allowable Cost (MAC)** – the upper limit cost paid to a Participating Pharmacy for specified Prescription Drugs. The MAC applies to Generic drugs, and when appropriate, Brand-name drugs included in the Formulary. We may modify the list at any time without the consent of any Covered Person, or Participating Pharmacy. A change in the MAC status of a drug may affect the Copayment/Coinsurance You are required to pay for that drug.

**National Drug Code (NDC) number** - a number maintained by the Food and Drug Administration (FDA) that uniquely identifies all Prescription Drug products.

**Non-Covered Drug** – a drug or product for which coverage is not available through Mercy Health Plans. Non-Covered drugs or products include, but are not limited to, those specifically excluded by the Policy or this addendum.

**Non-Participating Pharmacy (Non-Network Pharmacy)** – a pharmacy that has **NOT**:

- Entered into an agreement with Us or Our designee to provide Prescription Drugs to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drugs.
- Been designated by Us as a Participating Pharmacy.

**Participating Pharmacy** – a pharmacy that has:

- Entered into an agreement with Us or Our designee to provide Prescription Drugs to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drugs.
- Been designated by Us as a Participating Pharmacy.

A Participating Pharmacy can be a retail, mail service, or specialty pharmacy.

**Predominant Reimbursement Rate** – the amount We will reimburse You for a Prescription Drug that is dispensed by a Non-Participating Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug includes a dispensing fee and may include sales tax. We calculate the Predominant Reimbursement Rate using Our Prescription Drug Cost that applies to that Prescription Drug at most Participating Pharmacies.

**Prescriber** – A duly licensed health care provider who has issued a Prescription Order or Refill.

**Prescription Drug** – a medication that has been approved by the Food and Drug Administration (FDA) for use in the treatment of any indication provided the drug has been recognized as safe and effective for treatment of the specific type of indication in any of the following: (1) the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium drug evaluations; (2) The American Hospital Formulary Service drug information; (3) The United States Pharmacopoeia dispensing information; or (4) two articles from major peer-reviewed professional medical journals that have not had their effectiveness contradicted in another article from a major peer-reviewed professional medical journal. A Prescription Drug can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. Prescription Drugs are given a status of Tier One (or “First Tier”), Tier Two (or “Second Tier”), Tier Three (or “Third Tier”), Tier Four (or “Fourth Tier”), or Not Covered by the Plan’s Formulary Committee. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of this benefit, this definition also includes:

- Inhalers (with spacers)
- Insulin
- The following diabetic supplies:
  - insulin syringes with needles
  - blood testing strips – glucose
  - urine testing strips – glucose
  - ketone testing strips and tablets
  - lancets and lancet devices
  - glucose monitors

**Prescription Drug Cost** – the rate We have agreed to pay Our Participating Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug dispensed at a Participating Pharmacy.

**Prescription Order** – the directive to dispense a Prescription Drug issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

### **Prior Authorization**

Before certain Prescription Drugs are covered, Your Physician is required to obtain Prior Authorization from Us. There are several reasons for obtaining Prior Authorization, including determining whether the Prescription Drug, in accordance with Our approved guidelines, meets the definition of a Covered Service and is not Experimental, Investigational, or Unproven, or in some cases, simply to notify the Plan that a member may qualify for additional services such as case management. The list of Prescription Drugs requiring Prior Authorization is subject to Our periodic review and modification. You may obtain a current list of Prescription Drugs that require Prior Authorization through the Internet at [www.mercyhealthplans.com](http://www.mercyhealthplans.com) or by calling Our Customer Contact Center at the telephone number on Your ID card.

### **Quantity Limits**

Benefits for Prescription Drugs are subject to the Quantity Limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the Benefit Information table in Section IV. For a single Copayment/Coinsurance, You may receive a Prescription Drug up to the stated Quantity Limit.

Note: Some Prescription Drugs are subject to additional Quantity Limits based on criteria that We have developed. The limit may restrict either the amount dispensed per Prescription Order or Refill, or the number of refills during a specified time frame.

You may obtain a current list of Prescription Drugs that have been assigned maximum Quantity Limits for dispensing through the

Internet at [www.mercyhealthplans.com](http://www.mercyhealthplans.com) or by calling Our Customer Contact Center at the telephone number on Your ID card. The list is subject to Our periodic review and modification.

**Refill** – A second or subsequent dispensation of a prescription drug as authorized by a Prescription Order.

**Service Charge** – a charge in addition to applicable Copayment/Coinsurance. A Service Charge is equal to the difference between the cost of the Prescription Drug as dispensed and the cost of the generic substitute reflected by the Maximum Allowable Cost.

**Specialty Pharmaceutical** – any Prescription Drug used to treat a complex, often chronic disease that requires complex care management. Specialty Pharmaceuticals include those drugs used to treat rheumatoid arthritis multiple sclerosis, hepatitis C and other chronic diseases. They are typically high-cost and often require special handling, and close monitoring of the patient's condition. Most Specialty Pharmaceuticals are subject to coverage limitations and may have limited distribution through certain specialty pharmacies. See Section IV. Benefit Information for more details.

### **Step Therapy**

Step therapy is a program similar to Prior Authorization. It ensures use of clinically appropriate drugs in a cost effective manner. Step therapy protocols are based on current medical findings, FDA-approved drug labeling, and drug costs.

Step therapy drugs are considered either "first-line" or "second-line". A first-line drug and its corresponding second-line drug are both used to treat the same conditions. First-line drugs are drugs that are commonly prescribed, safe and effective in treating a given condition, and are typically less expensive than second-line drugs.

Second-line drugs are not covered unless You have tried a first-line therapy. If for some reason You cannot try the first-line drug, a Prescriber can request a medical exception to bypass the step therapy requirement.

**Tier One** – Tier One drugs will incur Your lowest Copayment/Coinsurance and are typically those drugs classified as Generic by First Databank or Medi-Span.

**Tier Two** – Tier Two drugs will incur a higher Copayment/Coinsurance than a Tier One Drug and a lower Copayment/Coinsurance than a Tier Three or Tier Four Drug. Tier Two drugs may be classified as either Generic or Brand by First Databank or Medi-Span.

**Tier Three** – Tier Three drugs will incur a higher Copayment/Coinsurance than a Tier One or Tier Two drug, and a lower Copayment/Coinsurance than a Tier Four drug. Tier Three drugs may be classified as either Generic or Brand by First Databank or Medi-Span.

**Tier Four** – Tier Four drugs incur Your highest Copayment/Coinsurance and are typically Specialty Pharmaceuticals. They may be classified as either Brand or Generic by First Databank or Medi-Span.

**Usual and Customary Charge** – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties.

## II. INTRODUCTION

### What's Covered - Outpatient Prescription Drug Benefits

We provide benefits under this Rider for Prescription Drugs designated as covered at the time the Prescription Order or Refill is dispensed by a Participating Pharmacy. Refer to exclusions in Your Policy and in Section V of this Rider.

### Coverage Policies and Guidelines

Our Formulary Management Committee reviews all Prescription Drugs that are newly approved by the FDA. The committee objectively evaluates Prescription Drugs for therapeutic treatment, safety, and cost in order to establish coverage policies and guidelines, such as Quantity Limits, Step Therapy and Prior Authorization, that promote quality and cost-effective drug therapy. Prescription Drugs are given a status of Tier One (or "First Tier"), Tier Two (or "Second Tier"), Tier Three (or "Third Tier"), Tier Four (or "Fourth

Tier"), or Non-Covered by the Plan's Formulary Committee. Drugs not added to the Formulary are considered Non-Covered.

Even after a Prescription Drug is included on the Formulary, this evaluation continues at least annually or as new information becomes available.

### Drug Cancellation Notification

Changes to the Formulary will be posted to the Plan's website at [www.mercyhealthplans.com](http://www.mercyhealthplans.com).

### Identification Card (ID Card)

You will be required to show Your ID card at the time You obtain Your Prescription Drug at a Participating Pharmacy. If Your card is not available at that time, You must provide the Participating Pharmacy with identifying information that We can verify during regular business hours.

If the pharmacy is unable to verify Your coverage or if the Prescription Drug is dispensed by a Non-Participating Pharmacy, You will be required to pay 100% of the cost of the Prescription Drug at the pharmacy. Our contracted pharmacy reimbursement rates (Our Prescription Drug Cost) will not be available to You.

You may seek reimbursement from Us by submitting the paid pharmacy receipt(s) to Us as outlined in the section, What You Must Pay.

### What You Must Pay

You are responsible for paying the applicable Copayment/Coinsurance, and any applicable Service Charge as described in the Schedule of Coverage and Benefits when Prescription Drugs are obtained from a retail, mail service, or specialty pharmacy. The Prescription Drug Copayment/Coinsurance is in addition to any other place-of-service Copayment/Coinsurance (i.e., medical office, home care, etc.).

Mercy Health Plans negotiates with Participating Pharmacies on your behalf for a discounted rate for Prescription Drugs. This discount is passed on to You when You use Your Mercy Health Plans drug coverage.

If a Participating Pharmacy is unable to verify Your coverage or if the Prescription Drug is dispensed by a Non-Participating Pharmacy, You will be required to pay 100% of the cost of the Prescription Drug at the pharmacy. Our contracted pharmacy reimbursement rates (Our Prescription Drug Cost) will not be available to You. You may seek reimbursement from Us by submitting the paid pharmacy receipt(s) within 60 days to:

Mercy Health Plans  
ATTN: Pharmacy Department  
14528 South Outer 40 Road, Suite 300  
Chesterfield, Missouri 63017

The receipt(s) must be submitted within sixty (60) days after the Prescription Drug is filled by the pharmacy. The receipt(s) must show the name of the Prescription Drug, the National Drug Code (NDC) number, the units dispensed, the days' supply, the prescription number, the amount You paid, and the date of purchase. Failure to furnish receipts within the time required will not invalidate any claim, if it was not reasonably possible to give notice within the time required.

When You request reimbursement for a Prescription Drug obtained at a Participating Pharmacy we will only reimburse You based on what We would have paid to the Participating Pharmacy less any required Copayment/Coinsurance and any applicable Service Charge. This means that You may not be refunded the full retail price that You originally paid. Any Quantity Limitations, Step Therapy, or Prior Authorization requirements will apply. We will not reimburse You for any Non-Covered Drug.

When You request reimbursement for a Prescription Drug obtained at a non-Participating Pharmacy, You will be responsible for the **greater** of 50% of the retail cost of the Prescription Drug *or* the in-Network Copayment/Coinsurance amount including any applicable Service Charge. This means that You may not be refunded the full retail price that You originally paid. Any Quantity Limitations, Step Therapy, or Prior Authorization requirements will

apply. We will not reimburse You for any Non-Covered Drug.

The amount You pay for any of the following under this addendum will not be included in calculating any Out-of-Pocket Maximum stated in Your Policy:

- Copayments and Coinsurances for Prescription Drugs
- Service Charges
- Annual Drug Deductible, if applicable
- Any Non-Covered drug. You are responsible for paying 100% of the cost for any Non-Covered drug.

### Medical Emergencies

When You obtain a Prescription Drug from a Non-Participating Pharmacy, as part of Emergency Care, You will be required to pay 100% of the cost for the Prescription Drug at the pharmacy. You may seek reimbursement from Us by submitting the paid pharmacy receipt(s) to Us as outlined in the section, What You Must Pay. Upon review of the relevant medical records and any other relevant information reasonably requested by Us, Our Chief Medical Officer or designee will determine whether the Prescription Drugs were in fact part of, or related to Emergency Care. If it is determined that the Prescription Drug was dispensed as part of Emergency Care, You will be reimbursed the cost incurred by You, less the appropriate Copayment/Coinsurance and any applicable Service Charge. If it is determined that the Prescription Drug was NOT dispensed as part of Emergency Care, You will pay the appropriate Non-Network Coinsurance and any applicable Service Charge.

### When a Brand-name Drug Becomes Available as a Generic

When a Prescription Drug becomes available as a Generic, the Brand-name version may no longer be available on the Formulary or the Copayment/Coinsurance may change. See the Schedule of Coverage and Benefits for details.

### Rebates and Other Payments to Us

We may receive rebates for certain Brand-name drugs included on Our Formulary. We do not consider these rebates in calculating any

percentage Copayments/Coinsurances. We are not required to pass on to You, and We do not pass on to You, amounts payable to Us under rebate programs or other such discounts.

**Coupons and Incentives**

At various times, We may offer coupons or other incentives for certain drugs on the Formulary. Only Your doctor can determine whether a change in Your Prescription Order or Refill is appropriate for Your medical condition.

**Limitation on Selection of Pharmacies/Prescribers**

If We determine that You are using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies and Prescribers may be limited. If this happens, We will notify You and require You to select up to two Participating Pharmacies and Prescribers who will provide and coordinate all future pharmacy services. If You don't make a selection within ten (10) days of the date We notify You, We will select a Participating Pharmacy and Prescriber for You. If You fail to use the selected providers, benefits for covered Prescription Drugs will not be paid.

**III. PAYMENT INFORMATION - See Your Schedule of Coverage & Benefits**

**IV. BENEFIT INFORMATION**

Description of Pharmacy Type and Supply Limits	Your Copayment/Coinsurance Amount
<p><b>Up to a 30 Day Supply of Prescription Drugs from a Participating Retail or Specialty Pharmacy</b></p> <p>As written by the Prescriber, <i>up to</i> a consecutive 30- day supply of a Prescription Drug, unless limited by the drug manufacturer's packaging size, or based on Quantity Limits, or to the extent a Prescription Drug is normally prescribed in limited supplies in accordance with generally accepted medical practice.</p> <p><i>See Glossary of Terms for definition of Prescription Drug.</i></p>	<p>See Your applicable Copayment/Coinsurance stated in the Schedule of Coverage and Benefits.</p>

Description of Pharmacy Type and Supply Limits	Your Copayment/Coinsurance Amount
<p><b>[A 31- to 90-Day Supply of Prescription Drugs from a Participating 90 Day Retail Pharmacy]</b></p> <p>Some retail Participating Pharmacies have entered into an agreement with Us that allows them to dispense up to a 90-day supply of certain Prescription Drugs. You may obtain a list of 90-day retail Participating Pharmacies through the Internet at <a href="http://www.mercyhealthplans.com">www.mercyhealthplans.com</a> or by calling Our Customer Contact Center at the telephone number on Your ID card.</p> <p>As written by the Prescriber, a 31- to 90-consecutive day supply of a Prescription Drug, unless limited by the drug manufacturer's packaging size, or based on Quantity Limits, or to the extent a Prescription Drug is normally prescribed in limited supplies in accordance with generally accepted medical practice.</p> <p><b>NOTE:</b> Specialty Pharmaceuticals are limited to <i>a maximum of a thirty (30)-day supply per Prescription Order or Refill.</i></p> <p><i>See Glossary of Terms for definition of Prescription Drug.]</i></p>	<p>See Your applicable Copayment/Coinsurance stated in the Schedule of Coverage and Benefits.</p>
<p><b>Prescription Drugs from a Mail Service Participating Pharmacy</b></p> <p>The following supply limits apply:</p> <ul style="list-style-type: none"> <li>As written by the provider, <i>up to</i> a consecutive 90- day supply of a Prescription Drug, unless limited by the drug manufacturer's packaging size, or based on Quantity Limits, or to the extent a Prescription Drug is normally prescribed in limited supplies in accordance with generally accepted medical practice.</li> <li><b>NOTE:</b> Mail order is not available for any Tier Four drugs.</li> </ul> <p>To receive the maximum Benefit, Your provider must write Your Prescription Order or Refill for the full 90-day supply. If You receive less than a 90-day supply from a Mail Service Pharmacy, You will still be required to pay the Mail Services Copayment/Coinsurance.</p> <p><i>See Glossary of Terms for definition of Prescription Drug.</i></p>	<p>See Your applicable Copayment/Coinsurance stated in the Schedule of Coverage and Benefits.</p>

Description of Pharmacy Type and Supply Limits	Your Copayment/Coinsurance Amount
<p><b>Prescription Drugs from a Non-Participating Pharmacy</b></p> <p>If the Prescription Drug is dispensed by a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us, as described in the Section II, <i>What You Must Pay</i>.</p> <p>In most cases, You will pay more if You obtain a Prescription Drug from a Non-Participating Pharmacy.</p> <p>The following supply limits apply:</p> <ul style="list-style-type: none"> <li>• As written by the provider, up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.</li> <li>• Any Quantity Limitations, Step Therapy, or Prior Authorization requirements will apply. We will not reimburse You for any Non-Covered Drug.</li> </ul>	<p>See Your applicable Copayment/Coinsurance stated in the Schedule of Coverage and Benefits.</p>

## V. WHAT'S NOT COVERED - EXCLUSIONS

The Coordination of Benefits in Your Policy does not apply to Prescription Drugs covered by this addendum. Except as modified or superseded by the coverage provided under this addendum, all other terms, conditions, exclusions in Your Policy remain unchanged and in full force and effect. In addition, the following exclusions apply:

1. Coverage for Prescription Drugs for any amount dispensed in excess of the supply limits addressed above and/or any additional Quantity Limits as discussed in Section II.
2. Drugs that are prescribed, dispensed, or intended for use while You are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
3. Experimental, Investigational, or Unproven services and medications; medications not approved by the FDA; medications used for experimental or unproven indications ("off-label" uses) and/or dosage regimens determined by Us to be experimental.
4. Prescription Drugs furnished by the local, state, or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state, or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
5. Prescription Drugs for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any Workers' Compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
6. Any product dispensed for the purpose of appetite suppression or weight loss.
7. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order.
8. Drugs available over-the-counter that do not require a Prescription Order by federal or state law before being dispensed.
9. Any drug that is therapeutically equivalent to an over-the-counter drug.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.

11. Replacement Prescription Drugs resulting from lost, stolen, damaged, spilled, or destroyed medications.
12. General and injectable vitamins, except prenatal vitamins that require a Prescription Order and are prescribed for a Covered Person who is then pregnant or attempting to conceive.
13. Unit dose packaging of Prescription Drugs.
14. Medications used for cosmetic purposes.
15. New Prescription Drugs and/or new dosage forms until they are reviewed and approved by Our Formulary Management Committee.
16. Prescription Drugs or dosage forms that are determined to not be a Covered Service.
17. Prescription Drugs or devices to treat erectile dysfunction including, but not limited to, impotency.
18. Drugs that are determined to be Non-Covered by Our Formulary Management Committee for any reason, including but not limited to, safety, efficacy, cost, narrow therapeutic index, etc.
19. Medical foods or other products that are intended to meet the distinctive nutritional requirements of a person with a particular disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a physician.
20. Prescription Drugs whose primary purpose or direct effect is the removal, destruction, or interference with the implantation of a fertilized ovum, embryo, or fetus.
21. Immunizations received through a Participating or Non-Participating pharmacy. See Your Policy for immunization services covered under Your medical Benefit.
22. Injectables/infusion medications which, due to its characteristics as determined by Us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception. See Your Policy for injectables/infusion services covered under Your medical Benefit
23. Growth hormone except as determined medically necessary by the Plan to treat diagnostically proven growth hormone deficiency. Growth hormone(s) to treat idiopathic short stature (ISS) is expressly excluded.
24. Contraceptive implant systems, diaphragms, and intrauterine devices (IUD).
25. Prescription Drugs when prescribed to treat infertility.
26. Prescription Drugs when prescribed to prevent conception, including but not limited to oral contraceptives, diaphragms, intrauterine devices, Nuva Ring, Depo Provera and other injectable drugs used for contraception, unless otherwise specified within this or other Plan documents, except when medically indicated for other than the purposes of preventing pregnancy, and pre-approved by the Plan.



---

Charles S. Gilham, Vice President  
Mercy Health Plans

SERFF Tracking Number:	MHPL-126444604	State:	Arkansas
Filing Company:	Mercy Health Plans	State Tracking Number:	44558
Company Tracking Number:			
TOI:	H16I Individual Health - Major Medical	Sub-TOI:	H16I.005A Individual - Preferred Provider (PPO)
Product Name:	Arkansas Individual 2010 - New Block		
Project Name/Number:	Arkansas Individual 2010 - new block of business/		

## Rate Information

Rate data applies to filing.

<b>Filing Method:</b>	SERFF
<b>Rate Change Type:</b>	Neutral
<b>Overall Percentage of Last Rate Revision:</b>	0.000%
<b>Effective Date of Last Rate Revision:</b>	
<b>Filing Method of Last Filing:</b>	N/A

## Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Mercy Health Plans	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: MHPL-126444604 State: Arkansas

Filing Company: Mercy Health Plans State Tracking Number: 44558

Company Tracking Number:

TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)

Product Name: Arkansas Individual 2010 - New Block

Project Name/Number: Arkansas Individual 2010 - new block of business/

## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 02/01/2010	MHP Arkansas - New Plans 2010 - Exhibit 1		New		MHP Ark Ind New Plans 2010 Exh 1.pdf
Approved-Closed 02/01/2010	Age and Area Factors - Exhibit 2		New		MHP Ark Ind 2010 Age-Area Factors Exh 2 REVISED.pdf
Approved-Closed 02/01/2010	Arkansas Individual Rates - Exhibit 3		New		MHP Ark Ind 2010 Rates Exh 3.pdf
Approved-Closed 02/01/2010	Arkansas Individual Rates - Attachment 4		New		MHP Ark Ind Exp Proj 2010 Exh 4.pdf

## MHP Arkansas - New Plans 2010

### Exhibit 1

	ARK - A10		ARK - B10		ARK - C10		ARK
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Deductible	\$1,000	\$2,000	\$2,500	\$5,000	\$5,000	\$10,000	\$1,000
Coinsurance	80%	60%	80%	60%	80%	60%	80%
Out-of-Pocket	\$3,500	\$7,000	\$5,000	\$10,000	\$7,500	\$15,000	\$4,500
Hospital	100%	75%	100%	75%	100%	75%	80%
PCP Office Visit	\$30	75%	\$30	75%	\$30	75%	\$30
Specialist	\$60	75%	\$60	75%	\$60	75%	\$60
ER	\$200	\$200	\$200	\$200	\$200	\$200	\$200
Urgent Care	\$75	\$200	\$75	\$200	\$75	\$200	\$75
Preventive Health	100%	75%	100%	75%	100%	75%	100%
Ambulance	100%	100%	100%	100%	100%	100%	80%
Chiropractor	limited		limited		limited		limited
Vision	\$60		\$60		\$60		\$60
OP MH/SA	80%		80%		80%		80%
Rx Tier 1	\$10		\$10		\$10		\$10
Rx Tier 2	\$35		\$35		\$35		\$35
Rx Tier 3	\$70		\$70		\$70		\$70
Rx Tier 4	80%		80%		80%		80%

**- D10**

Out-of- Network
\$2,000
60%
\$9,000
60%

**ARK - E10**

In- Network	Out-of- Network
\$1,500	\$3,000
80%	60%
\$5,000	\$10,000
80%	60%

**ARK - F10**

In- Network	Out-of- Network
\$2,500	\$5,000
80%	60%
\$6,000	\$12,000
80%	60%

**ARK - G10**

In- Network	Out-of- Network
\$5,000	\$10,000
80%	60%
\$8,500	\$17,000
80%	60%

60%
60%
\$200
\$200
60%
80%

\$30	60%
\$60	60%
\$200	\$200
\$75	\$200
100%	60%
80%	80%

\$30	60%
\$60	60%
\$200	\$200
\$75	\$200
100%	60%
80%	80%

80%	60%
80%	60%
80%	60%
80%	60%
100%	60%
80%	80%

limited

\$60  
80%

limited

\$60  
80%

limited

80%  
80%


\$10	
\$35	
\$70	
80%	

\$10	
\$35	
\$70	
80%	

\$10	
\$35	
\$70	
80%	

**Mercy Health Plan  
Arkansas Individual Plans  
Age and Area Factors  
March 1, 2010**

**Exhibit 2**

**Age Factors**

<b>Age Band</b>	<b>Male</b>	<b>Female</b>
6 months - 1 yr	1.244	1.244
1-4	1.244	1.244
5-18	0.602	0.602
19-24	0.564	0.770
25-29	0.640	0.923
30-34	0.813	1.175
35-39	1.000	1.395
40-44	1.277	1.547
45-49	1.627	1.810
50-54	2.187	2.181
55-59	2.847	2.593
60-64	3.757	3.096
65+	3.757	3.096

**Area Factors**

<b>County</b>	<b>Region</b>	<b>Factor</b>
Benton	NW Arkansas	0.90
Carroll	NW Arkansas	0.90
Madison	NW Arkansas	0.90
Washington	NW Arkansas	0.90
Franklin	Fort Smith	1.00
Logan	Fort Smith	1.00
Scott	Fort Smith	1.00
Sebastian	Fort Smith	1.00
Clark	Hot Springs	1.10
Garland	Hot Springs	1.10
Hot Springs	Hot Springs	1.10
Montgomery	Hot Springs	1.10
Pike	Hot Springs	1.10
Baxter	Springfield Border	0.92
Boone	Springfield Border	0.92
Fulton	Springfield Border	0.92
Marion	Springfield Border	0.92
Faulkner	Little Rock	1.05
Lonoke	Little Rock	1.05
Pulaski	Little Rock	1.05
Saline	Little Rock	1.05
White	Little Rock	1.05
All Other		1.35

REVISED JANUARY 22, 2010

**Mercy Health Plan**  
**Arkansas Individual Rates 2010**  
**Exhibit 3**

**Fort Smith**

<b>Male</b>	Mercy Health Plans
Age	New Block D
22	93.28
27	102.14
32	122.41
37	144.34
42	176.71
47	217.79
52	283.34
57	360.55
62	467.09

**Hot Springs**

<b>Male</b>	Mercy Health Plans
Age	New Block D
22	99.88
27	109.62
32	131.93
37	156.04
42	191.66
47	236.84
52	308.95
57	393.88
62	511.07

**NW Arkansas**

<b>Male</b>	Mercy Health Plans
Age	New Block D
22	86.68
27	94.65
32	112.90
37	132.63
42	161.77
47	198.73
52	257.74
57	327.23
62	423.11

**Springfield Border**

<b>Male</b>	Mercy Health Plans
Age	New Block D
22	88.00
27	96.15
32	114.80
37	134.97
42	164.76
47	202.54
52	262.86
57	333.89
62	431.91

**Little Rock**

<b>Male</b>	Mercy Health Plans
Age	New Block D
22	96.58
27	105.88
32	127.17
37	150.19
42	184.19
47	227.31
52	296.15
57	377.22
62	489.08

<b>Female</b>	Mercy Health Plans
Age	New Block D
22	127.48
27	162.37
32	180.16
37	190.58
42	208.37
47	239.16
52	282.59
57	330.82
62	389.70

<b>Female</b>	Mercy Health Plans
Age	New Block D
22	137.50
27	175.87
32	195.45
37	206.91
42	226.48
47	260.35
52	308.12
57	361.17
62	425.94

<b>Female</b>	Mercy Health Plans
Age	New Block D
22	117.46
27	148.86
32	164.87
37	174.25
42	190.26
47	217.97
52	257.06
57	300.46
62	353.46

<b>Female</b>	Mercy Health Plans
Age	New Block D
22	119.46
27	151.56
32	167.93
37	177.51
42	193.88
47	222.21
52	262.16
57	306.53
62	360.71

<b>Female</b>	Mercy Health Plans
Age	New Block D
22	132.49
27	169.12
32	187.80
37	198.74
42	217.43
47	249.75
52	295.35
57	346.00
62	407.82

Family Services Rider: Add \$4.50 to above premiums

Temporomandibular Joint Disorder (TMJ) Rider: Add \$2.00 to above premiums

## **Mercy Health Plan**

### **Arkansas Individual Rates 2010**

#### **Attachment 4**

#### **ARK Mercy One Claims Experience from 7/1/2008 to 3/31/2009**

*Trended forward to August 1, 2010*

*Member Month Exposure: 36,606*

*Average geographic factor was 1.00*

*Average duration was 5.8 months, so increased utilization by 26.2% to reflect average duration*

Net Paid Dollars (PMPM)	In-Network	Out-of-Network	Total
Inpatient Hospital	\$26.85	\$1.62	\$28.47
Outpatient Hospital	38.08	8.38	46.46
Physician Services	48.36	7.37	55.72
PBM	16.93	0.00	16.93
Other	1.59	0.38	1.97
<b>Total</b>	<b>\$131.80</b>	<b>\$17.75</b>	<b>\$149.55</b>

Back out average Age-Gender Factor in Experience 1.288

Back out average underwriting load (estimated) 1.163

**Male, Age 37 Net Paid Claims PMPM \$99.87**

Operating Expense Load \$21.82

Commissions 10.0%

Premium Tax 2.0%

Profit Load 8.0%

**Premium based on Experience \$152.11**



<i>SERFF Tracking Number:</i>	<i>MHPL-126444604</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Mercy Health Plans</i>	<i>State Tracking Number:</i>	<i>44558</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H16I Individual Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16I.005A Individual - Preferred Provider (PPO)</i>
<i>Product Name:</i>	<i>Arkansas Individual 2010 - New Block</i>		
<i>Project Name/Number:</i>	<i>Arkansas Individual 2010 - new block of business/</i>		

## Supporting Document Schedules

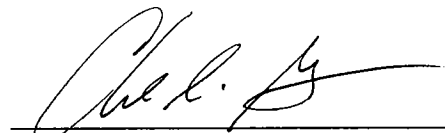
		Item Status:	Status Date:
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	02/01/2010
<b>Comments:</b>	The below 2 documents are:		
	1. Certification for Rule 19		
	2. Certification of Bulletin 9-85		
<b>Attachments:</b>			
	Certification.PDF		
	Certification of Bulletin 9-85.pdf		
		Item Status:	Status Date:
<b>Bypassed - Item:</b>	Application	Approved-Closed	02/01/2010
<b>Bypass Reason:</b>	See Application under Form Schedule tab.		
<b>Comments:</b>			
		Item Status:	Status Date:
<b>Satisfied - Item:</b>	Health - Actuarial Justification	Approved-Closed	02/01/2010
<b>Comments:</b>			
<b>Attachments:</b>			
	L122309JED ARK GLR Filing (2).pdf		
	Arkansas Individual Loss Ratio Guarantee.PDF		
	122209 ARK Ind Actuarial Memo.pdf		
		Item Status:	Status Date:
<b>Bypassed - Item:</b>	Outline of Coverage	Approved-Closed	02/01/2010
<b>Bypass Reason:</b>	N/A		
<b>Comments:</b>			

<i>SERFF Tracking Number:</i>	<i>MHPL-126444604</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Mercy Health Plans</i>	<i>State Tracking Number:</i>	<i>44558</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H16I Individual Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16I.005A Individual - Preferred Provider (PPO)</i>
<i>Product Name:</i>	<i>Arkansas Individual 2010 - New Block</i>		
<i>Project Name/Number:</i>	<i>Arkansas Individual 2010 - new block of business/</i>		

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Age and Gender Factor - revised	Approved-Closed	02/01/2010
<b>Comments:</b>			
Please note that the Age and Area Factors - revised - are included in the Rate/Rule Schedule tab.			
<b>Attachment:</b>			
Age Gender Objection Response.pdf			

CERTIFICATION

I, Charles S. Gilham, am a duly authorized officer of Mercy Health Plans and do hereby certify that, per Rule and Regulation 19 and 42, Section 5 (b), there will be no unfair discrimination with respect to the medical/lifestyle application questions and underwriting standards.




Charles S. Gilham, Vice President General Counsel  
Mercy Health Plans  
14528 S. Outer 40, Suite 100  
Chesterfield, MO 63017  
cgilham@mhp.mercy.net  
(314) 628-3696

1-8-10

Date

## CERTIFICATION

I, Charles S. Gilham, a duly authorized officer of Mercy Health Plans with the title of Secretary, do hereby certify that all benefits payable to a Network and Non-Network Provider comply with the requirements outlined in Arkansas Bulletin 9-85 and that the difference between Network and Non-Network deductible, copays and coinsurances will not exceed 25%.



---

Charles S. Gilham, Secretary  
Mercy Health Plans  
14528 South Outer 40, Suite 100  
Chesterfield, MO 63017  
Charles.gilham@mercy.net  
314-628-3696

1-15-10

---

Date

January 6, 2010

Ms. Rosalind Minor  
Senior Certified Rate and Form Analyst  
Arkansas Insurance Department  
Life and Health Division  
1200 West Third Street  
Little Rock, AR 72201-1904

**RE: PREMIUMS FOR NEW MERCY HEALTH PLAN INDIVIDUAL PRODUCTS**

Dear Ms. Minor:


Enclosed for filing are premium rate tables for new Mercy Health Plan individual major medical products. These are being filed with guaranteed loss ratios, and the guarantees are enclosed. Pursuant to ASA Section 23-79-110(5) (A), the rates will be deemed approved as filed when the Arkansas Department of Insurance receives the filing. The filing is informational only.

The prior individual major medical products are being discontinued, with no change in current rates. The attached rates are for new products, which are to be effective on or after March 1, 2009. The enclosed Actuarial Memorandum explains the premium rate development.

This will not affect any policyholders in Arkansas as they are new products.

If you have any questions, please contact me as shown below.

Sincerely,



James E. Drennan, F.S.A., M.A.A.A.  
Principal  
Ingenix Consulting  
2170 Satellite Blvd, # 150  
Duluth, GA 30097  
678-417-4904  
678-417-4950 fax  
Jim.drennan@ingenixconsulting.com

## Arkansas Individual Loss Ratio Guarantee

Mercy Health Plans will guarantee a minimum incurred loss ratio for calendar year 2010 and for each calendar year thereafter until new rates are filed and implemented. This guarantee is based on the following targeted loss ratios:

Policy Year	Target Incurred Loss Ratio
1	47%
2	58%
3	61%
4	69%
5+	74%

Incurred loss ratios will be determined by dividing incurred claims from this policy form by earned premiums for each calendar year, based on financial reports published after March 31 of the following year. The result of the calculation will be reported to the Arkansas Department of Insurance no later than the date for filing the Accident and Health Policy Experience in June. The report will be independently audited at Mercy Health Plan's expense.

Small blocks of business are not actuarially credible. If the earned premium on this block is less than \$1,000,000 in any given year, then results will be accumulated until the end of the calendar year in which \$1,000,000 of premium is attained. Please note that this block is Arkansas-specific and there is no national experience to pool and thereby attain credible results.

If the incurred loss ratio is less than the targeted incurred loss ratio, a refund will be made to Arkansas policyholders. An illustration of the calculation of refund is attached as Exhibit A.

I am authorized to make this guarantee on behalf of Mercy Health Plans.

George A. Schneider  
George Schneider  
Chief Financial Officer

January 8, 2010  
Date

## Exhibit A

### Calculation and Illustration of Refund Methodology

Refunds will be distributed by check to policyholders whose policies are in force as of the last day of the time period at issue, in proportion to the premium the policyholder paid in the time period at issue, according to the following formula:

$$\text{Policyholder Refund} = (\text{PH Premium} \div \text{Total Premium}) \times \text{Total Refund}$$

Where,

**PH Premium** is the earned premium paid by the policyholder during the time period,

**Total Premium** is the total premium paid by all Arkansas policyholders during the time period who will receive a refund, and

**Total Refund** is the amount to be refunded by Arkansas plus interest at the statutory rate from the end of the experience period until date of payment

Because small refunds require excessive administrative costs, any refunds less than \$10.00 will not be made to policyholders. Instead, these refunds otherwise payable will be aggregated and paid to the Arkansas Department of Insurance.

#### Illustration of refund calculation

Policy Year	Target Loss Ratio	Premiums	Target Claim Cost	Actual Claim Cost
1	47%	\$500,000	\$235,000	\$250,000
2	58%	450,000	261,000	240,000
3	61%	400,000	244,000	225,000
Total		\$1,350,000	\$740,000	\$715,000

The target loss ratio is 54.81% ( $\$740,000 \div \$1,350,000$ )

The actual loss ratio is 52.96% ( $\$715,000 \div \$1,350,000$ )

Because the actual loss ratio is less than the target loss ratio, a Total Refund of \$25,000 ( $\$740,000 - \$715,000$ ) plus interest would be payable. This Total Refund would be distributed according to the formula above.



# **Mercy Health Plans of Missouri, Inc.**

## ***Actuarial Memorandum and Certification***

### **PURPOSE AND SCOPE**

I, James E. Drennan, am a Member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. My company, Ingenix Consulting, was retained by Mercy Health Plans of Missouri, Inc. (MHP) to review the claim experience and prepare a rate certification filing with the Arkansas Department of Insurance for the rates for new plans offered by MHP.

The purpose of this memorandum is to document the rates for new MHP individual major medical products effective March 1, 2010. The prior individual major medical products are being discontinued, with no change in current rates. The rates in this filing are for all the new individual plans, and the description of coverage is enclosed. It is not appropriate to use this actuarial rate certification for any other purposes.

These are being filed with guaranteed loss ratios, and the Individual Loss Ratio Guarantees are enclosed. Pursuant to ASA Section 23-79-110(5) (A), the rates will be deemed approved as filed when the Arkansas Department of Insurance receives the filing. The filing is informational only.

### **BENEFITS**

Benefit options for the new plans are described in the New Plan Summary enclosed in Attachment 1.

### **AREA FACTORS**

Area factors have been added based on provider network analysis combined with the limited experience available. A summary of the factors is enclosed in Attachment 2.

### **AGE FACTORS**

Age factors have been revised for the new plans to be consistent with those used in other marketing regions with credible experience. A summary of the factors is enclosed in Attachment 2.

### **RATE SUMMARY**

The proposed premium rate tables are enclosed in Attachment 3. Premium rates for individuals will vary by benefit plan design, underwriting, age/gender, and area.

### **EXPERIENCE**

The development of projected base rates for 2010 is shown at Attachment 4, and was based on the experience of the closed block.

## **ACTUARIAL CERTIFICATION**

I, James E. Drennan, have reviewed the premium and claim experience used to develop proposed rates for the individual products in Arkansas. I relied on the staff of Mercy Health Plan, and reviewed the information for reasonableness.

I certify that the rates developed are not excessive, or unfairly discriminatory between policyholders, and that the benefits are reasonable with respect to the rates produced by this methodology. In addition, I also certify that these rates comply with accepted actuarial practices.



---

December 23, 2009  
James E. Drennan, FSA, MAAA  
Principal  
Ingenix Consulting  
2170 Satellite Blvd. # 150  
Duluth, GA 30097

Phone Number: (678) 417-4904

January 26, 2010

Ms. Rosalind Minor  
Senior Certified Rate and Form Analyst  
Arkansas Insurance Department  
Life and Health Division  
1200 West Third Street  
Little Rock, AR 72201-1904

**RE AGE AND GENDER FACTORS FOR NEW MERCY HEALTH PLAN INDIVIDUAL PRODUCTS**

Dear Ms. Minor:

On January 15, we received correspondence indicating your concern with our proposed age and gender factors for our new individual health product. Specifically, because our new product does not include a maternity benefit, you believed that the female factors appeared to be too high in comparison with the male factors.

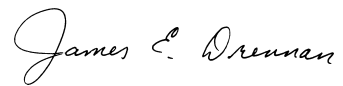
Most of this difference between genders reflects the higher utilization of health care services commonly seen among younger females, regardless of pregnancy. This includes more frequent visits to the doctor, additional lab tests and a higher use of prescription medication. You would have noticed, of course, that our male rates are higher than our female rates for members aged 50 and older. Female costs are actually lower than those of their male counterparts at these older ages, perhaps due to the additional preventive care received females receive earlier in their lives.

While we believe there are sound actuarial reasons for pricing younger females higher than younger males, we also believe the differentiation in our original factors is too great. We are submitting a new age and gender factor exhibit that effectively lowers our female rates from ages 19 to 24 by 10%, ages 25 to 29 by 20% and ages 30 to 34 by 10%. These changes result in a rating differential between genders that is more in-line with the marketplace,

This will not affect any policyholders in Arkansas as they are new products.

If you have any questions, please contact me as shown below.

Sincerely,

A handwritten signature in cursive script that reads "James E. Drennan".

James E. Drennan, F.S.A., M.A.A.A.  
Principal  
Ingenix Consulting  
2170 Satellite Blvd, # 150  
Duluth, GA 30097  
678-417-4904  
678-417-4950 fax  
[Jim.drennan@ingenixconsulting.com](mailto:Jim.drennan@ingenixconsulting.com)

SERFF Tracking Number: MHPL-126444604 State: Arkansas

Filing Company: Mercy Health Plans State Tracking Number: 44558

Company Tracking Number:

TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)

Product Name: Arkansas Individual 2010 - New Block

Project Name/Number: Arkansas Individual 2010 - new block of business/

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/06/2010	Form	MercyOne Application Checklist	01/27/2010	AR Individual Application_2010.pdf (Superseded)
01/06/2010	Supporting Document	Flesch Certification	01/26/2010	Certification.PDF
01/06/2010	Rate and Rule	Age and Area Factors - Exhibit 2	01/26/2010	L122309JED ARK GLR Filing (2).pdf (Superseded)

# MercyOne Application Checklist

Please follow this checklist to ensure your application is complete and avoid unnecessary underwriting delays.

- ☐ Complete the General Member Information section (page \*). Include the name, gender, height, weight, social security number, and date of birth for every person applying for coverage.
- ☐ Request an effective date on (page \*). You may select either the 1<sup>st</sup> or 15<sup>th</sup> of the month.
- ☐ Obtain and send to Mercy Health Plans a copy of any Certificate of Creditable Coverage, if you have had prior health insurance coverage through another carrier. We will need a copy of this Certificate in order to grant you a waiver for any pre-existing conditions.
- ☐ Select the plan option for which you will be applying (page \*).
- ☐ Answer all Health History questions (page \* and \*). Also, list all prescriptions and over-the-counter medications taken for each person applying for coverage. Failure to answer these questions will delay the underwriting of your application.
- ☐ Give us complete details in the attached *Secondary Health Questionnaire*, if you answered "yes" to any Health History conditions listed on page \* (question # 6). The page number(s) listed next to the condition(s) in this section refer to corresponding questions in the *Secondary Health Questionnaire*.
- ☐ List the primary care physician, phone number, and date of last visit for each person applying for coverage (page\*).
- ☐ Sign and date the Authorization to Use and Disclose Protected Health Information (page\*). This applies to each enrolling Applicant age 18 or over. **If your application is dated more than 60 days before the requested effective date, you will be asked to re-apply.**
- ☐ Complete the Payment Information (page \*). Payment for this policy can be made by automatic withdrawal from a checking or savings account. Mercy Health Plans also accepts Visa, MasterCard or American Express credit card payments.

If you need assistance in completing your application, please contact your agent. If you do not have an agent, please contact the MercyOne Sales Department (501) 372-0065 or (800) 330-8293, or email: [mercynearkansas@mercy.net](mailto:mercynearkansas@mercy.net).



Mercy Health Plans  
521 President Clinton Avenue • Suite 700  
Little Rock, AR 72201  
(501) 372-0065 • 800-330-8293  
www.mercyhealthplans.com

# Individual Application for Comprehensive Health Insurance



Please complete in black only.

## Application Type

Coverage Information (Select One): ☐ New Coverage \_\_\_\_\_ Effective Date Requested: \_\_\_\_/\_\_\_\_/\_\_\_\_  
☐ Change to current plan Member Number: \_\_\_\_\_ Effective Date of Change: \_\_\_\_/\_\_\_\_/\_\_\_\_  
☐ Add dependent (s) to current coverage Member Number: \_\_\_\_\_ Effective Date of Change: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Applicant Information

Please enter the following applicant information: (If applying for *Child Only* Coverage, record the child's information in the following section. Please submit a separate application for each Child Only Applicant.)

NAME: First Middle Last Subscriber's Occupation: \_\_\_\_\_  
HOME ADDRESS: (Street & P.O. Box if applicable) City State Zip County

Home Phone: (\_\_\_\_) \_\_\_\_\_ Best time to call: ☐ Day ☐ Evening E-mail (this will not be shared with a 3rd party): \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone #: (\_\_\_\_) \_\_\_\_\_

Are you a United States citizen? ☐ Yes ☐ No  
If "No", do you possess a Green Card (Permanent Resident Card) or a temporary U.S. visa? ☐ Yes ☐ No If "No", please explain: \_\_\_\_\_

Are you a legal resident of the state of Arkansas? ☐ Yes ☐ No If "No", please explain: \_\_\_\_\_

Have you resided in the United States for the past six (6) consecutive months? ☐ Yes ☐ No

## General Member Information

Please complete information below for all family members applying for coverage (attach other pages, if needed).

Name			Relationship to Applicant	Sex M/F	Height		Weight Lbs.	SSN#	Date of Birth (mm/dd/yyyy)		
First	MI	Last			Ft.	In.					
			Self								
			Spouse								
			Child								
			Child								
			Child								
			Child								
			Child								

Will the Mercy Health Plans' coverage that you are applying for **replace** or **change** your current hospital, medical or major medical insurance? ☐ Yes ☐ No

Will any applicants be **continuing** any other health insurance? ☐ Yes ☐ No If 'Yes', list name(s) : \_\_\_\_\_

## Producer Information

If you have a Producer (Broker or Agent) that will be assigned to your account, HAVE HIM/HER COMPLETE THIS SECTION.

**Note:** Mercy Health Plans (MHP) may share medical information with the Producer concerning you or your covered dependents that is contained in this application or discovered in the course of processing the application. The writing (and any assisting) Producer's current Arkansas health insurance license must be on file with MHP prior to acceptance of this application.

Do you know of any significant medical information relating to the applicant or any of his dependents that has not been reported on this form?

Yes ☐ No ☐

For purposes of processing commission, please provide the following information\*:

Agency Name: \_\_\_\_\_

Broker's Name: \_\_\_\_\_

Broker's Telephone # : \_\_\_\_\_

Broker's Email: \_\_\_\_\_

Broker's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Notification: Broker Only ☐ (Broker to receive policy)  
Broker and Subscriber ☐ (Member to receive policy, Broker to receive copy by email)

\* Please fill out this information as it appears on your W-9 form.

## Coverage and Benefit Selection

To choose the type of coverage that you would like, select ONE option from EACH of the sections numbered 1, 2, 3 and 4 below.

- 1) TYPE OF COVERAGE: ☐ Applicant only (Ages 19-65 yrs.) ☐ Child Only (Age 6 mos -18 yrs) ☐ Applicant & spouse  
☐ Applicant & unmarried children\* ☐ Applicant, spouse & unmarried children\*

*\*Unmarried children under age 19, or who are full time students (FTS) through the date on which they turn 23 may be added to the plan. FTS documentation must accompany application. Call us for details on FTS documentation at [(501) 372-0065] [or] [800-330-8293].*

- 2) EFFECTIVE DATE REQUESTED: \_\_\_\_/\_\_\_\_/\_\_\_\_ [1<sup>st</sup> or 15<sup>th</sup> of the month only]

*Note: The actual effective date will be determined by Mercy Health Plans, and if approved, you will be notified of the effective date for your policy.*

- 3) OPTIONAL RIDERS: Family Services Rider [(tubal ligations & vasectomies)] – Additional \$ \_\_\_\_ /month (per family) (Applies only to Applicant and enrolled spouse) ☐ Yes ☐ No

Temporomandibular Joint Disorder (TMJ) Rider – Additional \$ \_\_\_\_ /month/per applicant ☐ Yes ☐ No

- 4) PLAN SELECTION: Plan Option – Choose ONLY ONE Plan option

Plan	In network deductible Individual/Family	In network co-insurance after Deductible	Office Visit PCP/Specialist	Prescription Copay
<input type="checkbox"/> ARK - A - 10	\$1,000/\$2,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> ARK - B - 10	\$2,500/\$5,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> ARK - C - 10	\$5,000/\$10,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> ARK - D - 10	\$1,500/\$3,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> ARK - E - 10	\$1,000/\$2,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> ARK - F - 10	\$2,500/\$5,000	20%	\$30/\$60	\$10/\$35/\$70
<input type="checkbox"/> ARK - G - 10	\$5,000/\$10,000	20%	20% after deductible	\$10/\$35/\$70

Other Health Coverage			Yes	No																
Answer "Yes" or "No" and list and/or submit additional information as requested below.																				
1) Are you or anyone that is applying for coverage currently eligible for Medicare? If "yes", please list name(s): _____ _____ <b>Note: Anyone who is eligible for Medicare is not eligible for coverage under this Policy.</b>			<input type="checkbox"/>	<input type="checkbox"/>																
2) Have you ever had your coverage through Mercy Health Plans terminated for failure to pay premiums? If "yes", please list name(s): _____ If your coverage was terminated by Mercy Health Plans for non-payment of premiums, you must wait 12 months before applying for coverage and one month's advance premium may be required.			<input type="checkbox"/>	<input type="checkbox"/>																
3) Did you and/or your spouse and/or your eligible dependents have creditable coverage from a health insurance carrier within the past 63 days? (Creditable Coverage is any health insurance except a short term policy) If "yes", you may be eligible for pre-existing credit. If applicable, submit a copy of the Certificate of Creditable Coverage for each person applying.			<input type="checkbox"/>	<input type="checkbox"/>																
Lifestyle			Yes	No																
Answer "Yes" or "No" and list additional information as requested below.																				
1) Have you or any family member(s) who are applying for coverage smoked tobacco within the last 12 months? If "yes", list name(s): _____ <b>Note: Additional testing may be required to confirm this information.</b>			<input type="checkbox"/>	<input type="checkbox"/>																
2) Have you or any family member(s) who are applying for coverage used other smokeless tobacco products within the last 12 months? If "yes", list name(s): _____ <b>Note: Additional testing may be required to confirm this information.</b>			<input type="checkbox"/>	<input type="checkbox"/>																
3) Do you or any family member(s) who are applying for coverage use alcohol or illicit/recreational drugs? <b>If yes, complete below::</b> <table border="1" style="width: 100%;"> <thead> <tr> <th>Name</th> <th>Which do you/family member drink/use?</th> <th>How often do you/family member drink/use?</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td> <input type="checkbox"/> Alcohol  <input type="checkbox"/> Illicit Drugs  <input type="checkbox"/> Both alcohol &amp; drugs               </td> <td> <input type="checkbox"/> Seldom  <input type="checkbox"/> Occasionally  <input type="checkbox"/> Daily               </td> </tr> <tr> <td>_____</td> <td> <input type="checkbox"/> Alcohol  <input type="checkbox"/> Illicit Drugs  <input type="checkbox"/> Both alcohol &amp; drugs               </td> <td> <input type="checkbox"/> Seldom  <input type="checkbox"/> Occasionally  <input type="checkbox"/> Daily               </td> </tr> <tr> <td>_____</td> <td> <input type="checkbox"/> Alcohol  <input type="checkbox"/> Illicit Drugs  <input type="checkbox"/> Both alcohol &amp; drugs               </td> <td> <input type="checkbox"/> Seldom  <input type="checkbox"/> Occasionally  <input type="checkbox"/> Daily               </td> </tr> </tbody> </table>			Name	Which do you/family member drink/use?	How often do you/family member drink/use?	_____	<input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit Drugs <input type="checkbox"/> Both alcohol & drugs	<input type="checkbox"/> Seldom <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily	_____	<input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit Drugs <input type="checkbox"/> Both alcohol & drugs	<input type="checkbox"/> Seldom <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily	_____	<input type="checkbox"/> Alcohol <input type="checkbox"/> Illicit Drugs <input type="checkbox"/> Both alcohol & drugs	<input type="checkbox"/> Seldom <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily	<input type="checkbox"/>	<input type="checkbox"/>				
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4) Have you or any family member(s) who are applying for coverage used alcohol or illicit/recreational drugs in the past? If yes, complete below <table border="1" style="width: 100%;"> <thead> <tr> <th>Name</th> <th>When did you/family member stop using <u>alcohol</u>?</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____/_____(mm/yyyy)</td> </tr> <tr> <td>_____</td> <td>_____/_____(mm/yyyy)</td> </tr> <tr> <td>_____</td> <td>_____/_____(mm/yyyy)</td> </tr> </tbody> </table> <table border="1" style="width: 100%;"> <thead> <tr> <th>Name</th> <th>When did you/family member stop using <u>illicit drugs</u>?</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____/_____(mm/yyyy)</td> </tr> <tr> <td>_____</td> <td>_____/_____(mm/yyyy)</td> </tr> <tr> <td>_____</td> <td>_____/_____(mm/yyyy)</td> </tr> </tbody> </table>			Name	When did you/family member stop using <u>alcohol</u> ?	_____	_____/_____(mm/yyyy)	_____	_____/_____(mm/yyyy)	_____	_____/_____(mm/yyyy)	Name	When did you/family member stop using <u>illicit drugs</u> ?	_____	_____/_____(mm/yyyy)	_____	_____/_____(mm/yyyy)	_____	_____/_____(mm/yyyy)	<input type="checkbox"/>	<input type="checkbox"/>
Name	When did you/family member stop using <u>alcohol</u> ?																			
_____	_____/_____(mm/yyyy)																			
_____	_____/_____(mm/yyyy)																			
_____	_____/_____(mm/yyyy)																			
Name	When did you/family member stop using <u>illicit drugs</u> ?																			
_____	_____/_____(mm/yyyy)																			
_____	_____/_____(mm/yyyy)																			
_____	_____/_____(mm/yyyy)																			

[illegible]

5) List Primary Care Physician, phone number and date of last visit for each person applying:

Name of Applicant:	Primary physician name, phone number, city & state:	Date of last visit:

6) Do you or any family member(s) applying for coverage currently have or have ever been diagnosed or treated for any health conditions or diseases (either Inpatient, Outpatient or Emergency Room) pertaining to the following organ systems or diseases?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Check "Yes" or "No" for all conditions listed below as they apply for any covered family member.

**NOTE:** If you answer "Yes" to any of these screening questions, you must also answer the *Secondary Health Questionnaire* related to those conditions. The page numbers listed below refer to related questions in the attached *Secondary Health Questionnaire*.

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Diabetes/Sugar in Urine/Abnormal Blood Sugar/Pre-Diabetes, [pg *]	<input type="checkbox"/>	<input type="checkbox"/>	10. Nervous System/Brain Disorder/Headache/Epilepsy/Seizure Disorder, [pg*]
<input type="checkbox"/>	<input type="checkbox"/>	2. Endocrine/Thyroid/Pituitary/Adrenal, [pg *]	<input type="checkbox"/>	<input type="checkbox"/>	11. Mental or Psychiatric Condition/Depression/Behavioral (e.g., Attention-Deficit Hyperactivity Disorder) or Eating Disorder, [pg*]
<input type="checkbox"/>	<input type="checkbox"/>	3. High Blood Pressure/Hypertension, [pg *]	<input type="checkbox"/>	<input type="checkbox"/>	12. Back or Neck Disorder/Lumbago/Disc Herniation or Protrusion/Sciatica/Sacroiliac Disorder, [pg *]
<input type="checkbox"/>	<input type="checkbox"/>	4. Heart/Circulatory/Stroke/Aneurysm/Cholesterol, [pgs *]	<input type="checkbox"/>	<input type="checkbox"/>	13. Arthritis/Rheumatoid Arthritis/Bone/Joint Disorder/Inflammatory Joint Disorder/TMJ, [pgs *]
<input type="checkbox"/>	<input type="checkbox"/>	5. Respiratory/Lung/Asthma/Allergies/TB/COPD, [pg *]	<input type="checkbox"/>	<input type="checkbox"/>	14. Muscular Disorder/Lupus/Connective Tissue Disorder/Auto-Immune Disorder, [pg *]
<input type="checkbox"/>	<input type="checkbox"/>	6. Ears/Eyes/Nose/Throat/Skin Disorder, [pg *]	<input type="checkbox"/>	<input type="checkbox"/>	15. Cancers/Tumors/Cysts/Neoplasms, [pgs *]
<input type="checkbox"/>	<input type="checkbox"/>	7. Digestive/Intestinal/Liver Disorder/Acid Reflux/Crohn's/Polyps/ Hepatitis/Cirrhosis [pgs *]	<input type="checkbox"/>	<input type="checkbox"/>	16. HIV/AIDS/ARC/Chronic or Infectious Disease, [pg *]
<input type="checkbox"/>	<input type="checkbox"/>	8. Prostate/Reproductive Organ Disorder/Infertility/STD, [pg *]	<input type="checkbox"/>	<input type="checkbox"/>	17. Any Other Illness, Disease or Injury, [pg *]
<input type="checkbox"/>	<input type="checkbox"/>	9. Urinary Tract/Kidney or Renal Disease, [pg *]	<input type="checkbox"/>		

## Statements of Understanding

Please read all statements below.

1. I understand that this is an application only, and I should not cancel any coverage that I currently have until I am notified of acceptance for coverage by Mercy Health Plans (MHP).
2. I understand that I will receive either an acceptance, premium adjustment or denial from MHP, or a letter explaining the reason for the delay, within 60 days of MHP's receipt of this application.].
3. I understand that if the bank returns any payments due to insufficient funds, I will be assessed a fee. Additionally, I understand that if my premiums are not paid within the billing grace period, my coverage will be terminated as to the date when my premiums were paid in full. If my coverage is terminated, I will be unable to reapply for an Individual policy with Mercy Health Plans for one year.
4. I understand that if a Producer (Agent or Broker) is handling my request, the agent is not authorized to waive a complete answer to any question, make a decision as to insurability, make or alter any contract or waive any other rights or requirements of Mercy Health Plans.
5. I understand that if I or any covered family members am/are accepted for medical coverage, any pre-existing medical and/or mental health condition disclosed within this application will not be covered for up to 12 months after my effective date. (Credit may be given for prior creditable coverage upon receipt of certificate of creditable coverage.)
6. I understand that if any pre-existing condition(s) is/are subsequently discovered that were not disclosed during the application process, benefits will be withheld for 12 months for that condition or the coverage may be rescinded in its entirety at MHP's discretion.
7. I understand that I or any of my covered family members may need to obtain a physical examination at my own expense and submit the results as part of my application for coverage, if such an examination has not been performed within the last two years.
8. I understand that I or any of my covered family members have an obligation to notify Mercy Health Plans if we become aware of any medical conditions/injuries/disease states that would cause a reasonably prudent person to seek or require medical attention, from the time this application is signed to before the effective date of coverage. In this situation, MHP has the right to re-underwrite the application using this new information, and the decision to provide coverage may change.
9. I understand and agree that Mercy Health Plans may obtain or request information needed to process this application from me, my physician(s) and medical or pharmaceutical databases. A Mercy Health Plans' employee will then review this information. Any and all additions or corrections will then become part of the application. I understand that Mercy Health Plans will rely on this form and any information received to issue coverage.
10. I understand that if I omit or falsify information in a manner that is considered fraudulent or intentionally misleading, this may result in the cancellation of this coverage based on the terms of the policy. I agree to promptly repay any benefit payment(s) to which my covered family member(s) and/or I were not entitled.
11. I understand and agree that other health insurance coverage that I have might reduce my benefits under this Policy.

**Please note:**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

# Authorization to Use and Disclose Protected Health Information

NOTE: It is required that this *Authorization to Use and Disclose Protected Health Information* be completed and submitted with the application. The application is not complete without this authorization form.

Each person age 18 or over who is to be covered by this policy must sign at the bottom of this form.

I authorize Mercy Health Plans (MHP) or its affiliates to obtain necessary individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports from physicians, hospitals or other health care providers pertaining to my care or the care of any other dependent(s) listed on the application for insurance. I understand that this information can be used to determine my/our eligibility for insurance, and that those records can be requested as far back as the past ten years.

I authorize MHP to share necessary information with my Producer (Broker or Agent). I understand that Mercy Health Plans may disclose individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports to other entities in the course of its business operations or as required or permitted by law or as set out in the Mercy Health Plans Notice of Privacy Practices and authorize such disclosure. Federal regulations require that we inform you that under certain limited circumstances (e.g., judicial subpoena, state health department, etc.) the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by such regulation.

This authorization is valid for the duration of my coverage with Mercy Health Plans. I understand that this authorization is voluntary and that I may revoke this authorization at any time; however, if I do so before I am enrolled in the policy(ies), my application for coverage may be denied. A revocation request must be sent to MHP in writing to our home address, or via e-mail. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

By signing, I agree that I have fully read this entire application, including all seven (7) pages of the Secondary Health Questionnaire, and I understand and agree with all statements contained herein. I also certify that I have answered all questions on the application and Secondary Health Questionnaire completely and accurately. I understand and agree to the release of information for the purpose(s) described above in this document.

All listed applicants 18 years of age and older must agree to the terms of this authorization by signing below.

	Signature Required:	Printed Name:	Date:
Applicant	X		
Applicant's Spouse	X		
Dependent 18 yrs. or older	X		
Dependent 18 yrs. or older	X		
Dependent 18 yrs. or older	X		

If your application is dated more than 60 days before the requested effective date for coverage,  
a new application may need to be completed.

Note: Coverage will not begin until all necessary information is received by MHP.  
MHP will notify you of the approved effective date.

Applicant's Name: \_\_\_\_\_

## Payment Information

All premium payments are made **either** via debit ACH (automatic withdrawal) [or by] Credit Card payment\* [or by monthly invoice].

Please check your method of payment:

<input type="checkbox"/> <b>Monthly Invoice</b> – An invoice will be sent monthly to your home billing address unless a separate billing address is listed below:				
Name _____	Address (street and P.O. Box if applicable) _____	City _____	State _____	Zip _____

<input type="checkbox"/> <b>Automatic Bank Account Withdrawal</b>				
<input type="checkbox"/> Checking account (attach voided check below) <b>Account #</b> _____ <b>Routing #</b> _____				
<input type="checkbox"/> My first payment only	<input type="checkbox"/> My first and ongoing payments	<input type="checkbox"/> My ongoing payments only (first payment made by other method)		
<input type="checkbox"/> Savings Account (attach deposit slip) ) <b>Account #</b> _____ <b>Routing #</b> _____				
<input type="checkbox"/> My first payment only	<input type="checkbox"/> My first and ongoing payments	<input type="checkbox"/> My ongoing payments only (first payment made by other method)		
<i>I authorize Mercy Health Plans (MHP) to draft my Bank Account each month for the amount of my monthly premium. I understand that this authorization is in effect until I notify MHP in writing that I no longer desire these services, allowing them reasonable time to act upon my notification.</i>				
<b>Signature of Account Holder:</b>		<b>Date:</b>		
X		X		

<input type="checkbox"/> <b>Credit Card Payment</b>				
Type of Credit Card:	<input type="checkbox"/> VISA	<input type="checkbox"/> MasterCard	<input type="checkbox"/> American Express	
Credit Card Number: _____			Expiration Date: ____/____(mm/yy)	
Cardholder's Name (as it appears on the card): _____				
Cardholder's Address: _____		City _____	State _____	Zip _____
Telephone: _____				
<input type="checkbox"/> I authorize Mercy Health Plans to charge my credit card each month for the amount of my monthly premium.  <input type="checkbox"/> I authorize a one-time charge to my credit card for \$_____ premium [plus a 2% administration fee].				
<b>Signature of Cardholder:</b>		<b>Date:</b>		
X		X		

<input type="checkbox"/> <b>NEW LIST BILL</b> – Billing through a third-party (This option must have prior approval and requires separate List Bill forms to be completed and submitted with this application).  <input type="checkbox"/> <b>CHANGE TO EXISTING LIST BILL</b>				
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**Note:** You may be charged an additional fee for insufficient funds or incorrect banking information

Attach Voided Check Here

## SECONDARY HEALTH QUESTIONNAIRE

**Note: You must answer each question for yourself and for everyone you are applying for. Answer all categories 'YES' or 'NO'. If you answer 'YES' to a category, make sure to complete the detailed section not only for yourself but for everyone you are applying for.**

Have you/family member ever been diagnosed with, or sought treatment for any of the following conditions?

	YES	NO
<b>1. Diabetes/Sugar in Urine/Abnormal Blood Sugar/Pre-Diabetes/Hypoglycemia</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Diabetes/Pre-diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Which type of diabetes has been diagnosed?		
Type I, Insulin Dependent	<input type="checkbox"/>	<input type="checkbox"/>
If Type I, # units of insulin per day?		
<input type="checkbox"/> < 75 units <input type="checkbox"/> > 100 units		
<input type="checkbox"/> 75-100 units <input type="checkbox"/> Don't know		
Type II, Non-Insulin dependent	<input type="checkbox"/>	<input type="checkbox"/>
Gestational	<input type="checkbox"/>	<input type="checkbox"/>
Date of delivery (in MM/YYYY)	____/____/____	
Other type/Don't know	<input type="checkbox"/>	<input type="checkbox"/>
Date initial diabetes diagnosis made: (MM/YYYY)	____/____/____	
Oral meds to control blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>
Provide recent HbA1c or average glucose levels (within last six months).		
If fasting glucose levels		
<input type="checkbox"/> 65-115 <input type="checkbox"/> 116-175 <input type="checkbox"/> >175		
If random glucose levels		
<input type="checkbox"/> <200 <input type="checkbox"/> 201-250 <input type="checkbox"/> >250		
If HbA1c level _____		
In addition, do you/family member have any of these conditions?		
Diabetic eye complications	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems/Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
<b>2. Endocrine System/Thyroid/Pituitary/Adrenal</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Hyperthyroidism/Hashimoto's Thyroiditis/Graves Disease/Excess thyroid hormone	<input type="checkbox"/>	<input type="checkbox"/>
What kind of treatments have you/family member had for this?		
<input type="checkbox"/> Surgery <input type="checkbox"/> Radioactive Iodine <input type="checkbox"/> Other		
If surgery, date of surgery: (MM/YYYY)	____/____/____	
If surgery not done, does RX control disease?	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism-low thyroid hormone	<input type="checkbox"/>	<input type="checkbox"/>
Toxic Thyroid Goiter-Plummer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
When was diagnosis made (in MM/YYYY)?	____/____/____	
Hyperparathyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Did you/family member have surgery for?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, does medication control disease?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	
Hyperaldosteronism (Cushing's disease)	<input type="checkbox"/>	<input type="checkbox"/>
Is the cause of disease known?	<input type="checkbox"/>	<input type="checkbox"/>
If cause is known, describe condition:		
_____		
_____		
Date condition diagnosed: (in MM/YYYY)	____/____/____	
Is the condition stable with treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Addison's Disease (Chronic Adrenal Insufficiency)	<input type="checkbox"/>	<input type="checkbox"/>

Growth Hormone Deficiency	<input type="checkbox"/>	<input type="checkbox"/>
Other Thyroid/Endocrine system disorder	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		
_____		

	YES	NO
<b>3. High Blood Pressure/Hypertension</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

THREE recent blood pressure readings in systolic/diastolic format

Systolic	Diastolic	Date Taken

Readings taken while on meds for hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
Diagnosed with malignant hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
Has the diagnosis of hypertension required:		
An ER visit?	<input type="checkbox"/>	<input type="checkbox"/>
A hospital stay?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
<b>4. Heart/Circulatory/Stroke/Aneurysm/Cholesterol</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Which type of aneurysm?		
<input type="checkbox"/> Abdominal/Descending Thoracic Aortic <input type="checkbox"/> Brain		
<input type="checkbox"/> Femoral/Peripheral <input type="checkbox"/> Other type		
Has aneurysm been operated on?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	
If NO, any further problems?	<input type="checkbox"/>	<input type="checkbox"/>
Hypercholesterolemia/Hyperlipidemia/High blood lipids/High blood cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
What are cholesterol levels (in mg/dl)?		
<input type="checkbox"/> <=220 <input type="checkbox"/> >220<=250		
<input type="checkbox"/> >250<=300 <input type="checkbox"/> >300		
Are above levels while on cholesterol meds?	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
What type of anemia do you/family member have?		
<input type="checkbox"/> Unknown/Other <input type="checkbox"/> Thalassemia Major		
<input type="checkbox"/> Pernicious <input type="checkbox"/> Iron Deficiency		
<input type="checkbox"/> Sickle Cell <input type="checkbox"/> Hemolytic Anemia		
If hemolytic, have you/family member had a splenectomy?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	
Bleeding disorders/Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease/Heart Attack/Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had?		
<input type="checkbox"/> Angioplasty/Balloon/Stent Procedure - How many? _____		
<input type="checkbox"/> Cardiac Bypass Surgery		
<input type="checkbox"/> Neither Angioplasty nor Bypass Surgery		
If performed, date procedure done: (MM/YYYY)	____/____/____	

If history of heart attacks, give date: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Congestive Heart Failure ☐ ☐

Is the only treatment drug therapy? ☐ ☐

Have you/family member had any hospitalizations for? ☐ ☐

Cardiomegaly/Enlarged heart ☐ ☐

Are you/family member a heart transplant candidate? ☐ ☐

Is the reason for the enlargement known? ☐ ☐

If known, describe: \_\_\_\_\_

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Do you/family member have any impairment from condition? ☐ ☐

Peripheral Vascular Disease/Claudication ☐ ☐

Is diagnosis? ☐ Reynaud's Disease ☐ Buerger's Disease ☐ Neither Reynaud's or Buerger's

Cerebral Vascular Accident (CVA)/Stroke/Transient Ischemic Attack (TIA)/Small Stroke ☐ ☐

Was diagnosis CVA or TIA? ☐ CVA ☐ TIA

Date symptoms began: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Any residual impairment? ☐ ☐

Arrhythmias/Atrial Fibrillation/Rhythm Problem ☐ ☐

Episodes are: ☐ Single ☐ Multiple ☐ Chronic

If multiple, are they controlled? ☐ ☐

If YES, are they controlled by? ☐ Drugs ☐ Surgical device

Conduction disturbances/Bundle Branch Blocks ☐ ☐

Cause known for conduction disturbances? ☐ ☐

If cause known, describe: \_\_\_\_\_

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Cardiac implantable device/pacemaker installed? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Chest pain/Angina/Ischemic Heart Disease ☐ ☐

Is clinical work up suggestive of coronary artery disease/blocked cardiac arteries? ☐ ☐

If NO, date of symptoms onset: (in MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Deep Vein Thrombosis/Blood Clots in Legs/Phlebitis ☐ ☐

Do you/family member currently have one of these conditions? ☐ ☐

Have you/family member had? ☐ Single episode ☐ Multiple episodes

If single episode, date of onset of symptoms: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

If multiple, date recovered from last episode: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Are you/family member on anti-clotting RX? ☐ ☐

Edema/Swelling of the extremities ☐ ☐

Do you/family member know what is causing swelling? ☐ ☐

If YES, describe: \_\_\_\_\_

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Cardiac Valve disorders/Heart Murmur/Valve Prolapse/Regurgitation/Stenosis of Valve ☐ ☐

Have you/family member had surgery for condition? ☐ ☐

If YES, was the valve: ☐ Repaired ☐ Replaced

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

If NO, are you/family member symptomatic? ☐ ☐

Carotid Artery Occlusion ☐ ☐

Is disease symptomatic and documented? ☐ ☐

Have you/family member had surgery to correct? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Cardiomyopathy ☐ ☐

Are you/family member on the waiting list for heart transplant? ☐ ☐

Do you/family member know what is causing cardiomyopathy? ☐ ☐

If YES, describe: \_\_\_\_\_

Pericarditis ☐ ☐

Did you/family member have surgery? ☐ ☐

If surgery, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Other disease of the heart or circulatory system ☐ ☐

Please describe: \_\_\_\_\_

	YES	NO
<b>5. Respiratory/Lung Disorder/Asthma/TB/COPD</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: \_\_\_\_\_

Allergies/Asthma ☐ ☐

Do you/family member have? ☐ Asthma & Allergies ☐ Allergies Only ☐ Asthma Only

If allergies, are you/family member on desensitization shots? ☐ ☐

If asthma, are attacks occasional or frequent? ☐ Occasional ☐ Frequent

If asthma, any hospitalizations for? ☐ ☐

If asthma, nebulizer used for acute episodes? ☐ ☐

If asthma, are you/family member taking corticosteroids? ☐ ☐

Is asthma under control with medications? ☐ ☐

Chronic Obstructive Lung Disease (COPD) or Emphysema ☐ ☐

Sleep Apnea ☐ ☐

If YES, do you/family member have a C-Pap machine? ☐ ☐

If NO, has it been recommended by a health care provider that you/family member get a C-Pap machine? ☐ ☐

Have you/family member had surgery for? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Bronchitis ☐ ☐

In last two years number of hospitalizations for bronchitis? ☐ Not at all ☐ One time ☐ > Than once

Pulmonary Embolism/Pulmonary Infarction ☐ ☐

Is it known what caused embolism/infarction? ☐ ☐

Please describe: \_\_\_\_\_

Single episode of symptoms? ☐ ☐

Are you/family member continuing anticoagulant drug treatment? ☐ ☐

Have you/family member fully recovered? ☐ ☐

Dyspnea/Shortness of Breath ☐ ☐

Known underlying condition causing this? ☐ ☐

Please describe underlying condition: \_\_\_\_\_

Is the shortness of breath exercise induced? ☐ ☐

How would you/family member characterize symptoms? ☐ Mild ☐ Moderate ☐ Severe

Pulmonary Hypertension ☐ ☐

Are you/family member a recipient/candidate for a lung transplant? ☐ ☐

Other respiratory condition ☐ ☐

Please describe: \_\_\_\_\_

	YES	NO
<b>6. Ear/Eye/Nose/Throat/Skin Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Middle ear infections/tubes in ears/Otitis Media ☐ ☐

Are infections chronic? ☐ ☐

Has there been more than one infection? ☐ ☐

Are tubes present in ear canals? ☐ ☐

Date of most recent episode: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Any hearing impairment? ☐ ☐

If YES, does it require a hearing aid? ☐ ☐

If YES, do you/family member need a cochlear implant? ☐ ☐

Cataracts ☐ ☐

Both eyes? ☐ ☐

Have you/family member had surgery on? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Glaucoma ☐ ☐

If YES, provide current ocular pressure: \_\_\_\_\_

Tonsillitis ☐ ☐

Have you/family member had surgery for? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Single episode of symptoms? ☐ ☐

Date of last episode of symptoms: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Psoriasis/Chronic Skin Condition/Eczema ☐ ☐

Episodes are: ☐ Mild ☐ Moderate ☐ Severe

Taking Enbrel/Other Biologic RX injections for? ☐ ☐

Acne ☐ ☐

Cellulitis-skin infection ☐ ☐

More than one episode? ☐ ☐

Are the episodes severe? ☐ ☐

When was since last episode? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Sinusitis/Sinus Infection ☐ ☐

Is condition chronic? ☐ ☐

How many infections do you/family member have a year? \_\_\_\_\_

Other Ear/Eye/Nose/Throat or Skin condition ☐ ☐

Please describe: \_\_\_\_\_

	YES	NO
<b>7. Digestive/Intestinal/Liver Disorder/Acid Reflux/Crohn's/Polyps/Hepatitis/Cirrhosis</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

GERD/Gastroesophageal Reflux Disease/Acid Reflux ☐ ☐

Did symptoms abate/improve with drug therapy? ☐ ☐

Are drugs you/family member taking prescribed by physician? ☐ ☐

Ulcers/Peptic Ulcers/Duodenal Ulcers/Gastric Ulcers ☐ ☐

Have you/family member had surgery for condition? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Crohn's Disease/Inflammatory Bowel Disease ☐ ☐

Have you/family member had surgery for condition? ☐ ☐

If YES, what kind of surgery was done? ☐ Partial bowel resection ☐ Total bowel resection

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Colitis/Irritable Bowel Syndrome (IBS)/Spastic Colitis ☐ ☐

☐ Currently under treatment

☐ Single Attack in the past

☐ Multiple Attacks in the past

If multiple date of last episode of symptoms: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Gastrointestinal Bleeding ☐ ☐

When was last bleeding episode? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Are you/family member currently under treatment? ☐ ☐

Cirrhosis of the Liver/Hepatitis/Liver Disease ☐ ☐

Which type of liver disease has been diagnosed?

☐ Cirrhosis ☐ Hepatitis C

☐ Hepatitis A ☐ Alcoholic Hepatitis

☐ Hepatitis B ☐ Chronic Hepatitis

If Hepatitis A, B or C - Normal liver function tests? ☐ ☐

If Hepatitis C - Taking Interferon by injection? ☐ ☐

Gall Bladder Disease/Cholelithiasis/Cholecystitis ☐ ☐

Was it a single attack of symptoms? ☐ ☐

Has the gall bladder been removed? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

If NO, date of last attack of symptoms? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Fatty Liver (NASH) ☐ ☐

Ulcerative Colitis/Chronic Inflammation of Colon ☐ ☐

Single or multiple episodes? ☐ ☐

Have you/family member had surgery for condition? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

If YES, are you/family member on prescription medications? ☐ ☐

If NO, is condition under control? ☐ ☐

If NO, are you/family member taking steroid medication? ☐ ☐

If NO, date last episode of symptoms: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Diverticulitis/Diverticulosis ☐ ☐

Do you/family member currently have symptoms from this? ☐ ☐

Have you/family member had surgery for? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Colon Polyps/Rectal Polyps ☐ ☐

Benign? ☐ ☐

Have you/family member had surgery on? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Hernia ☐ ☐

If YES, what kind of hernia?

☐ Inguinal ☐ Femoral

☐ Scrotal ☐ Ventral

Has it been operated on? ☐ ☐

If no, any symptoms from? ☐ ☐

If no operation and symptomatic, are symptoms managed by medicine? ☐ ☐

Pancreatitis ☐ ☐

**YES** **NO**

Is condition chronic or acute? ☐ ☐

Any history of alcohol use? ☐ ☐

Any subsequent liver disease? ☐ ☐

Single episode of pancreatitis? ☐ ☐

Do you/family member currently have this condition? ☐ ☐

If NO, date of last episode of symptoms: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Other digestive/intestinal disorder ☐ ☐  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_

	YES	NO
<b>8. Prostate/Reproductive Organ Disorder/Infertility/STD</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Uterine fibroids/Dysfunctional Uterine Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had a hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	
Was there a malignancy?	<input type="checkbox"/>	<input type="checkbox"/>
Benign Prostatic Hypertrophy/Prostatic Enlargement	<input type="checkbox"/>	<input type="checkbox"/>
Is there a malignancy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had prostate surgery?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	
Any symptoms or voiding difficulties related to prostatic enlargement?	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
Which type?		
<input type="checkbox"/> Genital Herpes-Date of last episode: (MM/YYYY)	____/____/____	
<input type="checkbox"/> Chlamydia - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gonorrhea - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Syphilis - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Venereal Warts - Is it present at this time?	<input type="checkbox"/>	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	<input type="checkbox"/>
If YES, are you/family member on infertility treatments?	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cysts	<input type="checkbox"/>	<input type="checkbox"/>
Are the cysts benign?	<input type="checkbox"/>	<input type="checkbox"/>
Any symptoms from condition?	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Dysplasia/Abnormal Pap Smears	<input type="checkbox"/>	<input type="checkbox"/>
More than one abnormal Pap in the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
Prolapsed Uterus	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had surgery to correct?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	
Do you/family member have a history of complications of pregnancies or deliveries?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member had an infant that was premature?	<input type="checkbox"/>	<input type="checkbox"/>
With congenital abnormalities/anomalies/defects?	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		
Other disorder/abnormality of the reproductive system	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

	YES	NO
<b>9. Urinary Tract/Kidney or Renal Disease</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Cystitis/Urinary Tract Infection (UTI)/Pyuria/Urethritis	<input type="checkbox"/>	<input type="checkbox"/>
Single episode?	<input type="checkbox"/>	<input type="checkbox"/>
When was last episode (in MM/YYYY)?	____/____/____	
Was there any protein/discharge/blood in urine?	<input type="checkbox"/>	<input type="checkbox"/>
Cystic disease of kidneys	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Solitary Cyst <input type="checkbox"/> Polycystic		
Have you/family member had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, date of surgery: (MM/YYYY)	____/____/____	

Have you or any family member applying for coverage had a kidney transplant ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Any post-surgical complications? ☐ ☐  
 Renal calculi/Kidney stones ☐ ☐  
 Currently have? ☐ ☐  
 If NO, date of last episode: (MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 More than two episodes of symptoms? ☐ ☐  
 Were stones in one or both kidneys? ☐ ☐  
☐ Unilateral/One kidney only  
☐ Bilateral/Both kidneys  
 Interstitial cystitis ☐ ☐  
 Currently have? ☐ ☐  
 If NO, date of last episode: (MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Acute Renal failure/Chronic Renal failure ☐ ☐  
 Currently have? ☐ ☐  
 If NO, date of recovery: (MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Urinary Incontinence ☐ ☐  
 Other Kidney/Urinary tract disorder ☐ ☐  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_

	YES	NO
<b>10. Nervous System/Brain Disorder/Headache/Epilepsy/Seizure Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Headaches/Migraines/Cluster Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Situational Headaches (menstrual, stress, other)?	<input type="checkbox"/>	<input type="checkbox"/>
Characterization of severity & frequency of headaches (Pick one):		
<input type="checkbox"/> Mild and/or less than 5/year <input type="checkbox"/> Severe and/or > 10/year		
<input type="checkbox"/> Moderate and/or 5 - 10/year <input type="checkbox"/> Onset less than 6 months		
Head Injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Was there a loss of consciousness?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, how long was loss of consciousness?	____/____/____	
<input type="checkbox"/> < 1 hour <input type="checkbox"/> < 1 day <input type="checkbox"/> More than 1 day		
If < 1 hour, any residual problems post recovery?	<input type="checkbox"/>	<input type="checkbox"/>
If < 1 day, give date of recovery: (MM/YYYY)	____/____/____	
If < 1 day, any residual problems post recovery?	<input type="checkbox"/>	<input type="checkbox"/>
Encephalitis/Encephalomyelitis	<input type="checkbox"/>	<input type="checkbox"/>
Currently have?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, any residual complications post recovery?	<input type="checkbox"/>	<input type="checkbox"/>
If NO, how long since recovery (in MM/YYYY)?	____/____/____	
Neuroma/Abnormal Nerve Growth	<input type="checkbox"/>	<input type="checkbox"/>
Is growth benign?	<input type="checkbox"/>	<input type="checkbox"/>
Have you/family member been operated on?	<input type="checkbox"/>	<input type="checkbox"/>
If YES, when was surgery (MM/YYYY)?	____/____/____	
If NO, when was recovery (MM/YYYY)?	____/____/____	
Is the diagnosis Morton's Neuroma?	<input type="checkbox"/>	<input type="checkbox"/>
Amyotrophic Lateral Sclerosis (ALS)/Lou Gehrig's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Reflex Sympathetic Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
If YES, have currently or recovered from?		
<input type="checkbox"/> Current <input type="checkbox"/> Recovered from		
If recovered, date of recovery: (MM/YYYY)	____/____/____	
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
If YES, have currently or recovered from?		
<input type="checkbox"/> Currently have <input type="checkbox"/> Recovered from		
If recovered, date of recovery: (MM/YYYY)	____/____/____	

Peripheral Neuropathy ☐ ☐  
 Is another disease condition causing neuropathy? ☐ ☐  
 If YES, please describe: \_\_\_\_\_

Epilepsy/Seizure Disorder ☐ ☐  
 Do you/family member know what type of seizure has been diagnosed? ☐ ☐  
 If YES, what is seizure type?  
☐ Febrile ☐ Petit Mal ☐ Jacksonian  
☐ Grand Mal ☐ Focal  
 Is another disease condition causing seizures? ☐ ☐  
 If YES, please describe: \_\_\_\_\_

Heat Exhaustion/Heat Stroke ☐ ☐  
 Which diagnosis? ☐ Heat Exhaustion ☐ Heat Stroke  
 Single episode? ☐ ☐  
 If NO, date of last episode: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Autism ☐ ☐  
 Cerebral Palsy ☐ ☐  
 Paralysis/Hemiplegia/Paraplegia ☐ ☐  
 Parkinson's Disease ☐ ☐  
 Spina Bifida ☐ ☐  
 Viral Meningitis ☐ ☐  
 Bacterial Meningitis ☐ ☐  
 Muscular Dystrophy ☐ ☐  
 Multiple Sclerosis ☐ ☐  
 Motor Neuron Disease ☐ ☐  
 Neuralgia/Neuritis ☐ ☐  
 Dementia ☐ ☐  
 Other disorder of the nervous system ☐ ☐  
 Please describe: \_\_\_\_\_

	YES	NO
<b>11. Mental or Psychiatric Condition/Depression/Behavioral (e.g., Attention-Deficit Hyperactivity Disorder) or Eating Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: \_\_\_\_\_

Affective Disorders ☐ ☐  
 What is diagnosis (pick one below)?  
☐ Obsessive Compulsive Disorder (OCD)  
☐ Panic Disorder ☐ Agoraphobia  
☐ Anxiety Disorder ☐ Neuroses  
 Is treatment effective? ☐ ☐  
 If YES, date treatment became effective? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 What is characterization of severity of symptoms?  
☐ Mild ☐ Moderate ☐ Severe  
 Schizophrenia/Paranoia ☐ ☐  
 Eating Disorder/Bulimia/Anorexia ☐ ☐  
 Do you/family member currently have an eating disorder? ☐ ☐  
 When was recovery? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Attention Deficit Disorder/ADD/ADHD ☐ ☐  

	YES	NO
What is characterization of severity of symptoms?		
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Are symptoms controlled by medication?	<input type="checkbox"/>	<input type="checkbox"/>
Situational Depression/Mild Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Is only current treatment prescription medication?	<input type="checkbox"/>	<input type="checkbox"/>

Major Depression/Bipolar Disorder ☐ ☐  
 When was diagnosis made? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Have you/family member ever sought, or are you seeking professional counseling/therapy for a mental health issue? ☐ ☐  
 Date of last treatment? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Other mental health/psychiatric disorder ☐ ☐  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

	YES	NO
<b>12. Back or Neck Disorder/Lumbago/Disc Herniation or Protrusion/Sciatica/Sacroiliac Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected: \_\_\_\_\_

Cervical (Neck) or Thoracic (Mid Back) or Lumbar (Low Back) Disc Herniation or Protrusion ☐ ☐  
 Are you/family member under current treatment for? ☐ ☐  
 Have you/family member had surgery for condition? ☐ ☐  
 If YES, any subsequent problems post-op? ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 If no surgery was done, have you/family member recovered? ☐ ☐  
 If you/family member have recovered, date of Recovery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Low Back Pain/Lumbago/SI Joint/Sciatica ☐ ☐  
 Are you/family member under current treatment for? ☐ ☐  
 If not in current treatment, date of last episode: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Spinal Fractures ☐ ☐  
 Any lingering neurological defects? ☐ ☐  
 Was fracture a compression fracture? ☐ ☐  
 When was last treatment (in MM/YYYY)? \_\_\_\_\_/\_\_\_\_\_  
 Spinal Stenosis ☐ ☐  
 Have you/family member had surgery for condition? ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Low Back Strain/Whiplash/Muscle Spasm ☐ ☐  
 Are you/family member under current treatment for? ☐ ☐  
 Ankylosing Spondylitis/Spondylolisthesis ☐ ☐  
 Have you/family member had surgery for condition? ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 If NO, is condition symptomatic/requiring treatment? ☐ ☐  
 Sciatica/Radiculitis/Radiating pain to legs or arms ☐ ☐  
 Do you/family member have any neurological defects? ☐ ☐  
 Are you/family member currently under treatment for? ☐ ☐  
 Are episodes recurrent? ☐ ☐  
 When was last episode (in MM/YYYY)? \_\_\_\_\_/\_\_\_\_\_  
 Spinal deformities/Scoliosis/Lordosis ☐ ☐  
 Have you/family member had surgery for condition? ☐ ☐  
 If surgery, any continuing problems post-op? ☐ ☐  
 If surgery was done, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 If no surgery, are you/family member currently under treatment? ☐ ☐  
 If you/family member are currently under treatment, is condition?  
☐ Mild ☐ Moderate ☐ Severe  
 If no current treatment, date of last treatment? (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 \_\_\_\_\_

Spina Bifida/Myelocoele ☐ ☐  
 Have you/family member had surgery for condition? ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 If YES, any residual neurological defects? ☐ ☐  
 Other back/neck disorder ☐ ☐  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

	YES	NO
<b>13. Arthritis/Rheumatoid Arthritis/Bone/Joint Disorder/Inflammatory Joint Disease/TMJ</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Arthritis ☐ ☐  
 Kinds of arthritis do you/family member have?  
☐ Degenerative ☐ Chronic proliferative  
☐ Hypertrophic ☐ Arthritis deformans  
☐ Senile ☐ Psoriatic  
☐ Juvenile Rheumatoid ☐ Chondrocalcinosis  
☐ Adult Rheumatoid ☐ Septic  
☐ Atrophic ☐ Acute Infectious  
☐ Osteoarthritis  
 Is condition asymptomatic? ☐ ☐  
 If symptomatic, date of first onset of symptoms: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Is more than one joint affected? ☐ ☐  
 If no, is the joint a hip or knee? ☐ ☐  
 Have you/family member had a hip/knee replacement? ☐ ☐  
 If you/family member had surgery, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Characterization of disease progression/degree of disability:  
☐ Mild, Minimal ☐ Moderate to Severe  
 Is there a joint infection? ☐ ☐  
 Osteomyelitis/Bone Infection/Bone Abscess ☐ ☐  
 Was there only a single episode? ☐ ☐  
 Involved joint/bone was:  
☐ Major joint/bone ☐ Minor joint/bone  
 TMJ Disorder/Disease ☐ ☐  
 TMJ Syndrome/Jaw Pain ☐ ☐  
 Under current treatment for? ☐ ☐  
 If NO, date treatment completed: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Bursitis/Tennis Elbow/Tendonitis/Synovitis ☐ ☐  
 Was there only a single episode of symptoms? ☐ ☐  
 Under current treatment for? ☐ ☐  
 Osteoporosis ☐ ☐  
 Is underlying cause known for condition? ☐ ☐  
 If YES, please describe cause for condition below:  
 \_\_\_\_\_  
 Any symptoms from? ☐ ☐  
 Any subsequent fractures? ☐ ☐  
 Do you/family member take steroids for condition? ☐ ☐  
 Carpal Tunnel Syndrome ☐ ☐  
 Have you/family member had surgery for? ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Ligament tears/Torn Meniscus/Osteochondritis/Dessicans/Chondromalacia ☐ ☐  
 Have you/family member had surgery for? ☐ ☐  
 If surgery, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 \_\_\_\_\_

Bone dislocation ☐ ☐  
 Was the dislocation (choose one, below)?  
☐ Congenital hip ☐ Patella (kneecap)  
☐ Shoulder ☐ Knee (not kneecap)  
☐ Hip-traumatic ☐ Other joint-traumatic  
 Was there a single episode of symptoms? ☐ ☐  
 Do you/family member currently have? ☐ ☐  
 Have you/family member had surgery on? ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Dislocation was:  
☐ Unilateral/one sided ☐ Bilateral/both sides  
 Bone fracture ☐ ☐  
 Has treatment been completed? ☐ ☐  
 Have you/family member had surgery on? ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Was the fracture? ☐ Union ☐ Non-Union  
 Was the fracture of?  
☐ Leg/hip/foot  
☐ Arm/hand/shoulder  
☐ Other bone  
 Foot pain ☐ ☐  
 Bunions ☐ ☐  
 If YES, have you/family member had surgery for? ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Plantar fasciitis ☐ ☐  
 Rotator cuff tear ☐ ☐  
 Have you/family member had surgery on? ☐ ☐  
 If YES, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Date of original injury: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Gout/Gouty Arthritis/Hyperuricemia ☐ ☐  
 Characterization of number of attacks:  
☐ Few ☐ Frequent  
 Are attacks well controlled by medication/diet? ☐ ☐  
 Other bone/joint disorder ☐ ☐  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

	YES	NO
<b>14. Muscular Disorder/Lupus/Connective Tissue/Autoimmune Disorder</b>	<input type="checkbox"/>	<input type="checkbox"/>

If YES, list family member(s) affected:

Collagen diseases:Scleroderma/Ehlers-Danlos Syndrome/Mixed Connective Tissue disease/Necrotizing Angiitis ☐ ☐  
 Lupus Erythematosus ☐ ☐  
 Fibromyalgia/Myitis/Myositis ☐ ☐  
 Currently being treated? ☐ ☐  
 If no current treatment, date of recovery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 Recurrent episodes? ☐ ☐  
 Polymyositis/Neuromyositis/Dermatomyositis ☐ ☐  
 Autoimmune Disorder/Disease ☐ ☐  
 Please describe: \_\_\_\_\_  
 \_\_\_\_\_  
 Ligament tears/Meniscus tears/Osteochondritis/Dessicans/Chondromalacia ☐ ☐  
 Have you/family member had surgery for condition? ☐ ☐  
 If surgery, date of surgery: (MM/YYYY) \_\_\_\_\_/\_\_\_\_\_  
 \_\_\_\_\_

Other Muscle/Connective Tissue/Autoimmune disorder ☐ ☐

Please describe: \_\_\_\_\_

**15. Cancer/Tumors/Cysts/Neoplasm**

YES NO  
☐ ☐

If YES, list family member(s) affected:

Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Basal Cell/Squamous Cell Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Lipoma/Adipose Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Colon/Rectal Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Melanoma	<input type="checkbox"/>	<input type="checkbox"/>
Other kind of cancer	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		

Are you/family member under current treatment? ☐ ☐

If NO, date treatment completed: (MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

What was stage of the tumor?

☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV

When diagnosed? (in MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

Was the treatment surgery alone? ☐ ☐

If YES, date of surgery: (MM/YYYY) \_\_\_\_/\_\_\_\_/\_\_\_\_

If not, what were the other treatments? ☐ ☐

Please describe: \_\_\_\_\_

Is cancer in remission? ☐ ☐

Is the cancer metastatic? ☐ ☐

Is the cancer recurrent? ☐ ☐

Have you/family member been told you have an abnormal, suspicious lesion/possible pre-malignant condition? ☐ ☐

Has the lesion been removed? ☐ ☐

Cyst ☐ ☐

Please describe: \_\_\_\_\_

Has the cyst been removed? ☐ ☐

YES NO

**16. HIV/AIDS/ARC Chronic or Infectious Disease**

☐ ☐

Have you or any family member applying for coverage been positively diagnosed or treated for HIV/AIDS/ARC Chronic or infectious Disease?

If YES, list family member(s) affected:

HIV (human immunovirus)	<input type="checkbox"/>	<input type="checkbox"/>
AIDS (Acquired Immune Deficiency Syndrome)	<input type="checkbox"/>	<input type="checkbox"/>
ARC (AIDS related complex)	<input type="checkbox"/>	<input type="checkbox"/>
Other chronic or Infectious disease	<input type="checkbox"/>	<input type="checkbox"/>
Please describe: _____		
_____		
_____		

YES NO

**17. Any other Illness, Disease, Condition or Injury**

☐ ☐

If YES, list family member(s) affected:

As a result of an injury or illness have you/family member had any of the treatments listed below?

Bone or skin graft(s)	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
Loss of limb	<input type="checkbox"/>	<input type="checkbox"/>
Loss or surgical removal of organ	<input type="checkbox"/>	<input type="checkbox"/>
If YES, please describe: _____		
_____		
_____		
_____		
_____		

Other Disease/Disease Condition/Disorder/Injury not previously described ☐ ☐

Please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of last treatment (in MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

Treating Physician: \_\_\_\_\_

January 6, 2010

Ms. Rosalind Minor  
Senior Certified Rate and Form Analyst  
Arkansas Insurance Department  
Life and Health Division  
1200 West Third Street  
Little Rock, AR 72201-1904

**RE: PREMIUMS FOR NEW MERCY HEALTH PLAN INDIVIDUAL PRODUCTS**

Dear Ms. Minor:

Enclosed for filing are premium rate tables for new Mercy Health Plan individual major medical products. These are being filed with guaranteed loss ratios, and the guarantees are enclosed. Pursuant to ASA Section 23-79-110(5) (A), the rates will be deemed approved as filed when the Arkansas Department of Insurance receives the filing. The filing is informational only.

The prior individual major medical products are being discontinued, with no change in current rates. The attached rates are for new products, which are to be effective on or after March 1, 2009. The enclosed Actuarial Memorandum explains the premium rate development.

This will not affect any policyholders in Arkansas as they are new products.

If you have any questions, please contact me as shown below.

Sincerely,



James E. Drennan, F.S.A., M.A.A.A.  
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